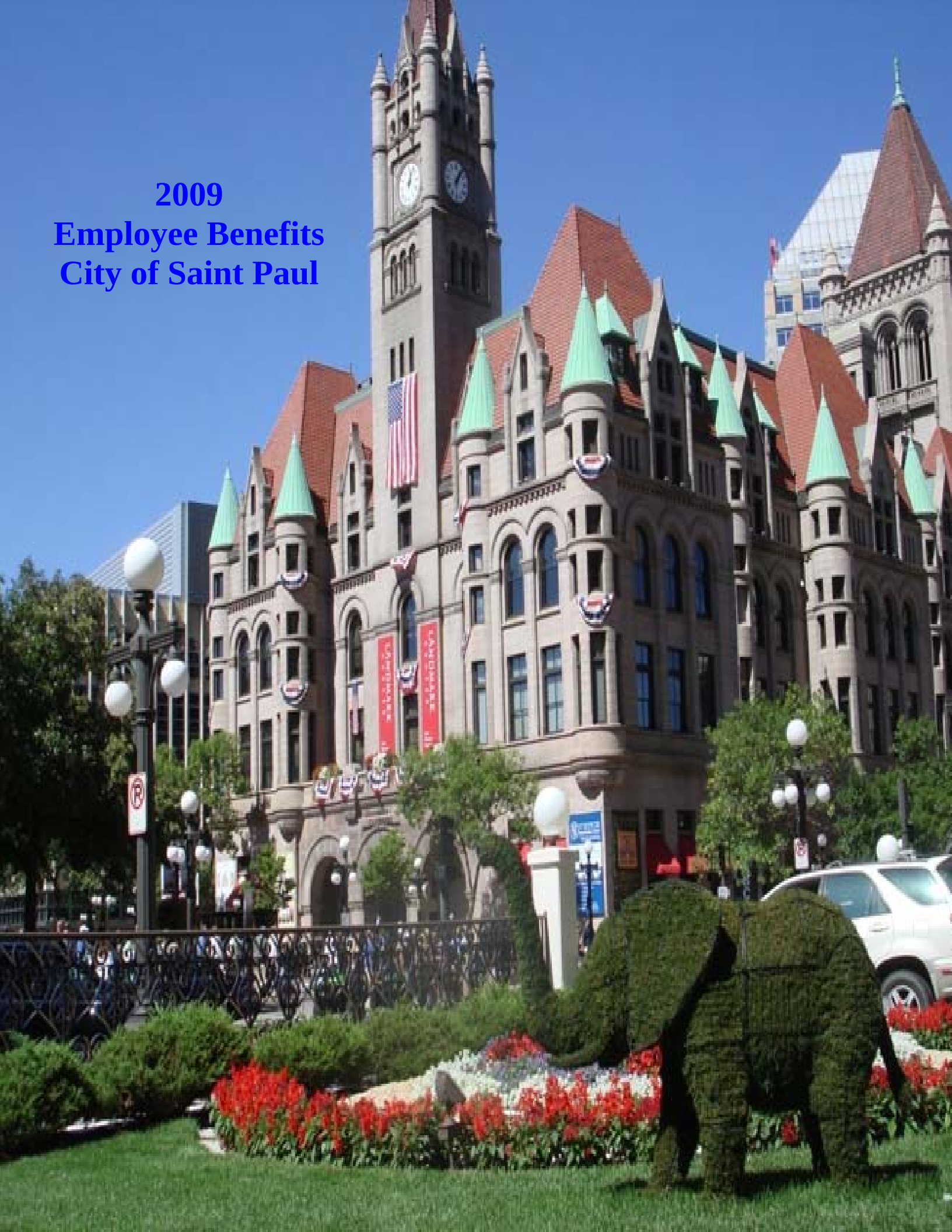
2009
Employee Benefits
City of Saint Paul



Insurance Benefit Program

The City of Saint Paul, through the action of the City Council and Mayor, has made available, for most employees and their eligible dependents, a program of life insurance and health benefits.

Eligible employees are those whose title and employment status satisfy the eligibility provisions of a collective bargaining unit agreement and/or applicable City Council resolutions.

The definition for eligible dependents (as it applies to health coverages) includes the subscriber's spouse and unmarried children to age 25, including stepchildren, adopted children and, with satisfactory proof of dependency, grandchildren and children under the legal guardianship of the subscriber. There may be tax implications, however, if the dependent does not meet the federal definition.

Children's eligibility can also be extended if the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

If you continue to carry ineligible dependents on your coverage, you will be required to pay retroactive premiums to the City and reimburse the health carrier for any claims paid on behalf of the ineligible dependent. Reimbursements will be required for the entire period during which the dependent was ineligible.

This booklet should be kept as an information source and referred to throughout the year. This booklet does not replace the cafeteria plan document, your collective bargaining unit agreement, or any other rules or regulations that govern employee benefits. Its purpose is to highlight that information which will be most useful and helpful to you in choosing your benefits.

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HEALTH INSURANCE

HealthPartners will continue to provide City-sponsored health care benefits for City of Saint Paul employees and their families in 2009. HealthPartners offers high quality health care and has been awarded "Excellent" Accreditation from the National Committee for Quality Assurance (NCQA). NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care. HealthPartners, a health plan whose mission is to improve health, offers comprehensive benefits, including coverage for preventive care when you use the network providers. HealthPartners provides online tools and phone resources to help you select your health care providers and get the care that best meets your needs. There are also tools and resources that provide information and support to help you improve your health. You have a choice of three HealthPartners plans, with different levels of coverage and premiums, so you can choose the benefits coverage and premium that is right for you and your family. These Plans are:

- HealthPartners Open Access Choice with Deductible
- HealthPartners Primary Clinic Choice with Deductible
- Distinctions Plan

Eligibility

Eligible employees are those whose title and employment status satisfy the eligibility provision of a collective bargaining unit agreement or applicable City Council resolution. Each eligible employee selects one of these plans. If family coverage is elected, each family member may select a different clinic from the plan's network.

Plans and Monthly Premiums

The 2009 premiums vary according to the plan you select. The amount of the City's contribution toward your health insurance premium is determined by your collective bargaining unit agreement or applicable City Council Resolution. See Benefit*Ready* for your contribution amounts.

HealthPartners Open Access Choice with Deductible

In the HealthPartners Open Access Choice with Deductible Plan, you do not need to select a primary clinic or physician and you may see any provider listed in the directory without a referral. The HealthPartners regional Open Access Network is among the largest in the area and offers direct access to nearly 27,000 primary and specialty care providers, as well as access to CIGNA HealthCare's national network of more than 565,000 medical providers and 5,000 hospitals. This plan also features an out-of-network benefit allowing direct access to any licensed provider worldwide. You receive the highest benefit level when you use a network provider, though you may opt to see non-network providers at a lower benefit level. Members first pay an annual deductible for in-network and out-of-network care, and then most benefits are covered at 80% when using the HealthPartners Open Access Network. After the annual out-of-pocket maximum is met, coverage is 100% for eligible expenses.

- Single: $ 467.84
- Family: $1,222.84

HealthPartners Primary Clinic Choice with Deductible
The HealthPartners Primary Clinic Choice with Deductible Plan combines the large HealthPartners Primary Clinic Network with out-of-network coverage. Members first pay an annual deductible for in-network and out-of-network care, and then most benefits are covered at 80% when using the HealthPartners Primary Clinic Network. After the annual out-of-pocket maximum is met, coverage is 100% for eligible expenses.

- Single: $ 575.43
- Family: $1,504.10

Distinctions Plan
The Distinctions Plan combines the HealthPartners Open Access Network with out-of-network coverage. This plan rates providers by the quality and cost of their care. You pay less to see Benefit Level I providers, more for Benefit Level II providers.

- Single: $ 650.29
- Family: $1,699.76

Enrolling in one of the three plan choices does not guarantee services by a particular provider. If you want to be certain of receiving care from a specific doctor, you should contact that doctor to ask whether or not the doctor is a HealthPartners network provider and whether or not the doctor is accepting additional patients. Access to health care services does not guarantee access to a particular type of doctor. Contact Member Services at (952) 883-5000 or (800) 883-2177 for specific information about access to different kinds of doctors.

PLEASE NOTE:

ALL EMPLOYEES WILL BE DEFAULTED

IF YOU DO NOT ENROLL ONLINE BY OCTOBER 17, 2008.

If you currently carry single coverage, you will be defaulted into the Primary Clinic Choice with Deductible ($500) plan. If you want a different plan, you must enroll online using the Benefit*Ready* system.

If you currently carry family coverage, you will be defaulted into the family Open Access with Deductible ($1,500) plan. If you want a different plan, you must enroll online using the Benefit*Ready* system.

If you currently waive medical insurance, or have lost medical coverage in 2008, you will continue to waive or have no medical insurance unless you enroll in a medical plan using the Benefit*Ready* system.

Changes for 2009
This is an overview of the changes on your medical plan for 2009.

Specialty drugs
Coverage of specialty drugs has changed. Specialty drugs are now covered at 80% subject to the deductible (if applicable) up to a member out-of-pocket maximum of $200 per specialty prescription per month.

Transplant Surgery
Out-of-pocket expenses for transplant surgery outside the network now do not apply to your annual out-of-pocket maximum. Also, your transplant surgery out-of-network lifetime maximum is now $25,000.

Inhalers and Migraine headache drugs – copay plans only
You will now pay a copay per month supply for these drugs.

Networks

Each available plan features in-network and out-of-network coverage. Following are brief descriptions of each network and a list of plans with which the network is available. For a complete directory listing, go to *www.healthpartners.com* or call Member Services at (952) 883-5000 or (800) 883-2177.

HealthPartners Open Access Network
The HealthPartners Open Access Network is among the largest in the area and offers direct access to nearly 27,000 primary and specialty care providers, as well as access to CIGNA HealthCare's national network of more than 565,000 medical providers and 5,000 hospitals. The HealthPartners Open Access Choice with Deductible Plan uses this network. Members who choose this plan do not choose a primary clinic and do not need referrals for specialty care. You can choose to go anywhere in the network every time you need care, including Mayo Clinic specialty providers.

Distinctions Network
The Distinctions Plan uses the HealthPartners Open Access network. The Distinctions plan allows you to choose doctors and clinics based on what's most important to you. HealthPartners rates providers using the industry's most sophisticated methods, so you can easily learn which providers offer the best cost and quality. This helps you make an informed choice when you want the best care for the best value. Distinctions also provides access to CIGNA HealthCare's national network.

HealthPartners Primary Clinic Network
The HealthPartners Primary Clinic Network features more than 27,000 providers and 188 hospitals. There are no claim forms to file when care is provided or authorized by a HealthPartners Primary Clinic Network physician. Members select a primary care clinic for most of their care. Members in the Primary Clinic Choice plans can go to any specialist in the entire HealthPartners Primary Clinic Network without a referral.

All providers in the HealthPartners Primary Clinic Network are also included in the HealthPartners Open Access Choice with Deductible, HealthPartners Primary Clinic Choice with Deductible, and HealthPartners Distinctions.

Out-of-Network Care
Out-of-network benefits are available with each plan after you satisfy an annual deductible (if necessary). The plan then pays 70% or 80% of the fee schedule amount for many health care services. However, routine physical and eye examinations and well-child care are not covered with out-of-network providers. You are responsible for payment to all out-of-network providers, and must submit a claim to be reimbursed for covered services.

Usual & Customary (U & C)
Out-of-network providers are paid at 100% for emergency benefits. For professional services, HealthPartners pays at the 50th percentile of a nationally recognized fair and reasonable schedule (usual and customary). The schedule is updated annually. HealthPartners applies standard usual and customary pricing methodologies to other ancillary and hospital services.

Enrollment

You must enroll using Benefit*Ready*, the City's online benefit system, at *www.benefitready.com* Remember to list your dependent information by selecting the "Dependent" tab under your Benefit*Ready* profile. When electing a medical or dental plan, choose the dependents you wish to cover by clicking next to each dependent's name.

If you are changing plans, it is critical to ensure that the clinics where you and your family members receive care are in the network affiliated with the plan you choose. If it is not part of the network, change your primary care clinic by calling HealthPartners Member Services at (952) 883-5000 or (800) 883-2177 before December 19, 2008 to select a primary clinic effective January 1, 2009. If you do not select a primary clinic and your plan choice requires one, a clinic will be assigned to you and your family members. You may also change clinics online by logging into your *Personal Page* on *healthpartners.com*. Additional information on changing your primary clinic is in the next section of this booklet.

The election that you make during open enrollment is for the entire plan year (January 1, 2009 through December 31, 2009). You may change your election only if you experience a status change event, as defined on page 32.

Clinics

When you first enroll in HealthPartners Primary Clinic Choice with deductible plan, you select primary medical and dental care clinics from which you receive most of your care. Each family member may choose a different primary care clinic within the network. You can change your primary care clinic selection at any time by calling HealthPartners Member Services at (952) 883-5000, toll-free at (800) 883-2177, or (952) 883-5127 for the hearing impaired. You can also change clinics online by logging into your *Personal Page* on *healthpartners.com*.

Clinic changes may take place at any time throughout the year; changes do not need to take place during open enrollment. Remember, selecting a primary care clinic doesn't restrict your choices. You continue to have the option – each time you need care – to receive care through the primary care clinic you select, or from an out-of-network provider. You'll receive the highest level of benefits when your care is provided by, or referred by, a provider in your primary care clinic. Your medical plan provides preventive dental benefits; for more extensive dental coverage, you can enroll in the optional HealthPartners Dental Distinctions plan (see page 51 for details). If you choose the optional HealthPartners Dental Distinctions plan, you can choose a different dental clinic than the one you chose under your medical plan.

Members choosing the HealthPartners Open Access Choice with Deductible plan or the Distinctions medical plan do not need to select a primary medical clinic.

HealthPartners Preferred Drug List (Formulary)

HealthPartners Preferred Drug List (Formulary) is a list of drugs that are covered at the highest level under your health plan. The HealthPartners Preferred Drug list, which is reviewed and updated throughout the year, lists prescription drugs that have been evaluated for safety, effectiveness, side effects, ease of use, and affordability. View the HealthPartners Preferred Drug List online at *www.healthpartners.com.*

When your personal physician prescribes something for you, it's a good idea to ask if the medication is on the HealthPartners Preferred Drug List. If it isn't, you may want to ask your physician whether a preferred drug list item would be suitable for you. In some cases, you may need a drug that is not on the preferred drug list. Your doctor can request that an exception be made so that the non-preferred drug list item can be covered. The clinical pharmacy staff reviews all these requests and decides when an exception is warranted for coverage. Generally, the decision will be made the same day as the request was made by your doctor.

Generic Brand Pharmacy Benefit

Your HealthPartners plan features a generic/brand pharmacy benefit. This means that:

- If you receive a generic drug at the pharmacy, you will pay $10 for the prescription.
- If a generic drug is not available and you receive a brand name drug, you will pay $20 for the prescription.
- If a generic drug is available, but you choose the brand name drug instead, you will pay the brand co-pay of $20 plus the cost difference between the generic and brand name prescriptions.

Want to find out how much your prescription will cost before you get to the pharmacy? Log on to your *Personal Page* on *healthpartners.com*. HealthPartners' Drug Cost Calculator will tell you the cost of your prescription based on your actual pharmacy benefit. The calculator also gives the cost for therapeutically equivalent and generic drugs that are less expensive than the brand name drug. If you don't have access to the internet, simply call the HealthPartners Member Services department at (952) 883-5000 or (800) 883-2177.

Provider Information and Directories

Please remember that the doctors and clinics available with any health plan are continually changing. The most current network information (updated weekly) is available online. Visit *http://www.healthpartners.com*. CD-ROM directories will be available at all open enrollment information sessions.

As always, if you have any questions about your HealthPartners networks or benefits, or need assistance with choosing a primary care clinic, HealthPartners Member Services is available to help. To get information about your provider network or benefits, call (952) 883-5000, toll-free at (800) 883-2177, or (952) 883-5127 for the hearing impaired, any time during the year.

Identification Cards

If you change health plans, you will receive a new identification card (ID card) before January 1, 2009, along with a Group Membership Contract and Member Handbook. If you keep your current plan, you will receive a Group Membership Contract and Schedule of Payments.

Termination of Employment or Leave of Absence

See page 69 for information on continuation of benefits.

Coverage

Benefit summaries for each of the three available plans are on pages 8 through 16. A quick-reference three-plan comparison is on page 18. These are intended as a general guide to your health insurance benefits. Full details of the plans are in your Group Membership Contract and Schedule of Payments.

Emergency Care

A medical emergency involves the sudden, life-threatening onset of illness or injury which demands medical attention, and when failure to get immediate care could cause serious harm. Some examples of medical emergencies are: uncontrollable bleeding; confusion or loss of consciousness, especially after a head injury; severe shortness of breath or difficulty breathing; apparent heart attack (severe chest pain, sweating, and nausea); and bone fractures.

If you experience a medical emergency within the service area, call 911 or go to the hospital affiliated with your primary care clinic. If you can't get to the hospital affiliated with your primary care clinic, then go to the nearest hospital for care. If you are hospitalized, notify your clinic within 48 hours or as soon thereafter as possible.

If you experience a medical emergency outside the service area, call 911 or go to the nearest hospital emergency room for treatment. If you are hospitalized, contact the HealthPartners CareCheck® program at (800) 942-4872 within 48 hours or as soon thereafter as possible.

Urgent Care

Urgent medical problems are those that, while not life-threatening, should be attended to on the same day or fairly soon. For example: ear infections in children, cuts that may require stitches, or an acute asthma episode. For urgent care needed during clinic hours, please call your clinic. For urgent care after your clinic's regular hours, you have several options:

- Call your clinic's after-hours line;
- Call the HealthPartners CareLine℠ nurse line at (612) 339-3663 or (800) 551-0859 to speak to a registered nurse; or
- Walk into any of the urgent care centers listed in the network directories.

Definition of Terms

The benefit summaries contain several terms which are defined below:

- **Co-insurance:** The percentage of costs the member must pay when receiving services, usually after paying a deductible.
- **Co-payment:** The fixed amount or percentage of eligible expenses the member must pay to the provider each time services are received.
- **Deductible:** The amount of eligible expenses members must pay each year before claims are reimbursable under the contract.
- **Discounts:** HealthPartners negotiates reduced rates with network providers. Those discounts are passed along to members who use a network provider.
- **Eligible Expense:** The charge billed by the provider for services covered by the plan.
- **Out-of-Pocket Maximum:** Payments you make for covered services (co-pays, co-insurance, and deductibles) are "out-of-pocket" expenses. Once you reach the limit specified by your plan, the plan covers 100% of additional eligible costs for the remaining calendar year.
- **Preventive Health Care:** Routine health exams, immunizations, pre-natal and post-natal care and exams, routine eye and hearing exams, routine screening procedures for cancer. Note: treatment of a condition or illness during a routine exam is not preventive health care; it is covered as an office visit.

Plan descriptions

The following pages provide a brief overview and benefit summaries of each of the three HealthPartners plans available to you for 2009. These are intended as a general guide to your health insurance benefits. Full details of the plans are in your Group Membership Contract and Schedule of Payments. You can also contact HealthPartners Member Services at (952) 883-5000, or visit with a HealthPartners representative at any of the open enrollment information sessions.

HealthPartners Open Access Choice with Deductible

In the HealthPartners Open Access Choice with Deductible Plan, you pay an annual deductible. Once the deductible is met, most benefits are covered at 80% when using the HealthPartners Open Access Network; you pay 20% of the costs. After the annual out-of-pocket maximum has been reached, HealthPartners pays 100%.

PLEASE NOTE: If you currently carry family coverage, you will be defaulted into the family Open Access with Deductible ($1,500) plan. If you want a different plan, you must enroll online using the Benefit*Ready* system.

Open Access Choice with Deductible	
Monthly Premium:	Single: $ 467.84 Family: $1,222.84
Network:	Open Access Network. Out-of-network benefits are also available.
Annual Deductible:	$1,500 for one person, $2,500 per family. A family deductible can be reached by 2 or more members reaching $2,500 (i.e., any combination of family members can cumulatively reach the $2,500 deductible amount). *Example –* Member #1 = $ 400 Member #2 = $ 800 Member #3 = $ 600 Member #4 = $ 700 $2,500 (the family deductible is met)
Annual Medical Out-of-Pocket Maximum:	Any deductible paid will apply towards the out-of-pocket maximum. Using the above example, the family annual out-of-pocket maximum is met even though none of the individual members have met the per person out-of-pocket maximum.
Preventive Health Care:	Deductible does not apply. HealthPartners pays 100% when you use a provider in the HealthPartners Open Access Network
Prescription Drugs:	Prescription co-pays do not apply to the deductible for in-network coverage, but do apply to the out-of-pocket maximum. The deductible applies when using out-of-network pharmacies, however. This coverage is the same as the other two plans offered; all three plans use the same pharmacy network.
Discounts:	You will be charged the network-associated discounted rates when you use the HealthPartners Open Access Network.
Co-Pay and Out-of-Pocket Maximum Changes:	No Changes.

HealthPartners Open Access Choice with Deductible

PARTIAL LISTING OF COVERED SERVICE	HEALTHPARTNERS PRIMARY CLINIC NETWORK	OUT-OF-NETWORK
	When care is provided by a HealthPartners Open Access provider.	*When care is provided by an out-of-network provider*
Lifetime maximum	Unlimited	$1,000,000
Calendar year deductible	$1,500 per person; $2,500 per family	$2,000 per person; $4,000 per family
Calendar year out-of-pocket maximum, medical and prescription combined	$2,500 per person; $2,500 per family	$3,000 per person; $6,000 per family
Preventive Health Care		
▪ **Routine physical & eye examinations, well-child care**	100% coverage	No coverage
▪ **Prenatal and postnatal care**	100% coverage	70% coverage after deductible
Office Visits		
▪ **Illness or injury**	80% coverage after deductible	70% coverage after deductible
▪ **Physical, occupational, & speech therapy**	80% coverage after deductible	70% coverage after deductible 20 visits per year
▪ **Chiropractic care** (neuromusculo-skeletal conditions only)	80% coverage after deductible	70% coverage after deductible 20 visits per year
▪ **Mental health care**	80% coverage after deductible	70% coverage after deductible 40 hours per year
▪ **Chemical health care**	80% coverage after deductible	70% coverage after deductible 130 hours per year
Inpatient Hospital Care		
▪ **Illness or injury**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible*
▪ **Mental health care**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible* 30 days per year
▪ **Chemical health care**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible* 73 days per year
Outpatient Care		
▪ **Scheduled outpatient procedures**	80% coverage after deductible	70% coverage after deductible*
▪ **Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)**	80% coverage after deductible	70% coverage after deductible*
Emergency Care		
▪ **Urgently needed care at an urgent care Clinic or medical center**	80% coverage after deductible	80% coverage after in-network deductible
▪ **Emergency care at a hospital ER**	80% coverage after deductible	80% coverage after in-network deductible
▪ **Ambulance**	80% coverage after deductible	HealthPartners in-network benefit
Home Health Care		
▪ **Physical, speech, occupational, & respiratory therapy, & home health aides**	80% coverage after deductible 120 visits per year	70% coverage after deductible 60 visits per year
Durable Medical Equipment		
▪ **Durable medical equipment & prosthetic devices**	80% coverage after deductible	70% coverage after deductible
Dental Care		
▪ **Treatment to restore damage done to sound, natural teeth as a result of accidental injury**	80% coverage after deductible	80% coverage after $50 deductible up to a $300 maximum
▪ **Preventive care for all ages, x-rays, exams, cleaning, fluoride treatment**	100% coverage	No coverage
*** CareCheck® Service**		

*To receive maximum benefits for hospitalizations including medical emergencies and same-day surgeries outside the HealthPartners Network, you must notify CareCheck® at (952) 883-5800 or (800)-942-4872. A utilization management specialist will review your proposed treatment plan, determine length of stay, approve additional days when needed, and review the quality and appropriateness of the care you receive. Benefits will be reduced by twenty percent if CareCheck® is not notified. Please refer to a Group Membership Contract for further information.

Formulary Prescription Drugs (up to a 30-day supply; or 1 cycle of oral contraceptives; and up to a 90-day supply for mail order) Tobacco cessation products are limited to coverage in-network and a 180 day supply per year	**HealthPartners Participating Pharmacy Benefit**	**Non Participating Pharmacy Benefit**
▪ **Retail Pharmacy**		
▪ Generic	$10 co-payment	70% coverage after deductible
▪ Brand	$20 co-payment	70% coverage after deductible
▪ **HealthPartners Mail Order Pharmacy**		
▪ Generic	$20 co-payment - 3 month supply	
▪ Brand	$40 co-payment - 3 month supply	
▪ **Specialty Drugs**	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx benefit
▪ **Allergy injections**	100% coverage	70% coverage after deductible
▪ **Immunizations**	100% coverage	70% coverage after deductible

HealthPartners Primary Clinic Choice with Deductible

In this plan you pay an annual deductible. After the deductible is met, most benefits are covered at 80% when using the HealthPartners Primary Clinic Network, requiring you to pay 20% of the costs. After the annual out-of-pocket maximum has been reached, HealthPartners pays 100%.

PLEASE NOTE: If you currently carry single coverage, you will be defaulted into the Primary Clinic Choice with Deductible ($500) plan. If you want a different plan, you must enroll online using the Benefit*Ready* system.

Primary Clinic Choice with Deductible	
Monthly Premium:	Single: $ 575.43 Family: $1,504.10
Network:	Primary Clinic Network (this is the same network the Primary Clinic Choice with Deductible and HealthPartners Distinctions plans use). Out-of-network benefits are also available.
Annual Deductible:	$500 for one person, $1,000 per family A family deductible can be reached by 2 or more members reaching $1,000 (i.e., any combination of family members can cumulatively reach the $1,000 deductible amount). *Example -* Member #1 = $ 200 Member #2 = $ 300 Member #3 = $ 400 Member #4 = $ 100 $1,000 (the family deductible is met)
Annual Medical Out-of-Pocket Maximum:	Any deductible paid will apply towards the out-of-pocket maximum. Using the above example, the family annual out-of-pocket maximum is met even though none of the individual members have met the per person out-of-pocket maximum.
Preventive Health Care:	Deductible does not apply. HealthPartners pays 100% when you use a provider in the HealthPartners Primary Clinic Network.
Prescription Drugs:	Not subject to the annual deductible for in-network coverage. The deductible applies when using out-of-network pharmacies, however. The maximum out-of-pocket for prescription co-pays is separate from the out-of-pocket maximum for medical. This coverage is the same as the other two plans offered; all three plans use the same pharmacy network.
Discounts:	You will be charged the network-associated discounted rates when you use the HealthPartners Primary Clinic Network.
Co-pay and Out-of-pocket Maximum Changes:	No changes.

HealthPartners Primary Clinic Choice with Deductible

PARTIAL LISTING OF COVERED SERVICE	HEALTHPARTNERS PRIMARY CLINIC NETWORK	OUT-OF-NETWORK
	When care is provided by a HealthPartners provider	*When care is provided by an out-of-network provider*
Lifetime maximum	Unlimited	$1,000,000
Calendar year deductible	$500 per person; $1,000 per family	$750 per person; $2,250 per family
Calendar year medical out-of-pocket maximum	$1,000 per person; $1,000 per family	$1,500 per person; $4,500 per family
Calendar year prescription out-of-pocket maximum	$1,000 per person; $1,000 per family combined for all covered prescriptions	
Preventive Health Care		
▪ **Routine physical & eye examinations, well-child care**	100% coverage	No coverage
▪ **Prenatal & postnatal care**	100% coverage	70% coverage after deductible
Office Visits		
▪ **Illness or injury**	80% coverage after deductible	70% coverage after deductible
▪ **Physical, occupational, & speech therapy**	80% coverage after deductible	70% coverage after deductible 20 visits per year
▪ **Chiropractic care** (neuromusculo-skeletal conditions only)	80% coverage after deductible	70% coverage after deductible 20 visits per year
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▪ **Chemical health care**	80% coverage after deductible	70% coverage after deductible 130 hours per year
Inpatient Hospital Care		
▪ **Illness or injury**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible*
▪ **Mental health care**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible* 30 days per year
▪ **Chemical health care**	80% coverage after deductible 365 days per period of confinement	70% coverage after deductible* 73 days per year
Outpatient Care		
▪ **Scheduled outpatient procedures**	80% coverage after deductible	70% coverage after deductible*
▪ **Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)**	80% coverage after deductible	70% coverage after deductible*
Emergency Care		
▪ **Urgently needed care at an urgent care Clinic or medical center**	80% coverage after deductible	80% of the first $2,500, then 100% coverage
▪ **Emergency care at a hospital ER**	80% coverage after deductible	80% of the first $2,500, then 100% coverage
▪ **Ambulance**	80% coverage after deductible	HealthPartners in-network benefit
Home Health Care		
▪ **Physical, speech, occupational, & respiratory therapy, and home health aides**	80% coverage after deductible 120 visits per year	70% coverage after deductible 60 visits per year
Durable Medical Equipment		
▪ **Durable medical equipment & prosthetic devices**	80% coverage after deductible	70% coverage after deductible
Dental Care		
▪ **Treatment to restore damage done to sound, natural teeth as a result of accidental injury**	80% coverage after deductible	80% coverage after $50 deductible up to a $300 maximum
▪ **Preventive care for all ages, x-rays, exams, cleaning, fluoride treatment**	100% coverage	No coverage
*** CareCheck® Service**		

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▪ **HealthPartners Mail Order Pharmacy**		
▪ Generic	$20 co-payment - 3 month supply	
▪ Brand	$40 co-payment - 3 month supply	
▪ **Specialty Drugs**	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx benefit
▪ **Allergy injections**	100% coverage	70% coverage after deductible
▪ **Immunizations**	100% coverage	70% coverage after deductible

Distinctions Plan

This plan offers the largest network. Your cost for care depends on who you see. We rate providers by the quality and cost of their care. You pay less to see Benefit Level I providers, more for Benefit Level II providers.

Distinctions Plan	
Monthly Premium:	Single: $ 650.29 Family: $1,699.76
Network:	The HealthPartners Open Access Network. Out-of-network benefits are also available.
Annual Deductible:	No deductible when you use the HealthPartners Open Access Network or the CIGNA HealthCare Network when traveling within the United States.
Annual Medical Out- of-Pocket Maximum:	Co-payments and co-insurance will apply towards the out-of-pocket maximum.
Preventive Health Care:	HealthPartners pays 100% when you use the HealthPartners Open Access Network.
Prescription Drugs:	Not subject to the annual deductible for in-network coverage. The deductible applies when using out-of-network pharmacies, however. This coverage is the same as the other two plans offered; all three plans use the same pharmacy network.
Co-pay and Out-of-pocket Maximum Changes:	No Changes.

Distinctions

PARTIAL LISTING OF COVERED SERVICE	HEALTHPARTNERS OPEN ACCESS NETWORK	OUT-OF-NETWORK
	When care is provided or authorized by your HealthPartners personal provider	*When care is provided by an out-of-network provider*
Lifetime maximum	Unlimited	$1,000,000
Calendar year deductible	None	$300 per person; $900 per family
Calendar year medical out-of-pocket maximum	$2,500 per person; $4,000 per family	$2,500 per person; $4,000 per family
Calendar year prescription out-of-pocket maximum	$500 per person; $1,000 per family combined for all covered prescriptions	
Preventive Health Care		
▪ **Routine physical & eye examinations, well-child care**	100% coverage	No coverage
▪ **Prenatal and postnatal care**	100% coverage	70% coverage after deductible
Office Visits		
▪ **Illness or injury**	$25 co-payment for Benefit Level 1 $40 co-payment for Benefit Level 2	70% coverage after deductible
▪ **Physical, occupational, & speech therapy**	$25 co-payment for Benefit Level 1 $40 co-payment for Benefit Level 2	70% coverage after deductible 20 visits per year
▪ **Chiropractic care** (neuromusculo-skeletal conditions only)	$40 co-payment	70% coverage after deductible 20 visits per year
▪ **Mental health care**	$25 co-payment	70% coverage after deductible 40 hours per year
▪ **Chemical health care**	$25 co-payment	70% coverage after deductible 130 hours per year
Inpatient Hospital Care		
▪ **Illness or injury**	100% coverage	70% coverage after deductible*
▪ **Mental health care**	100% coverage	70% coverage after deductible*
▪ **Chemical health care**	100% coverage	70% coverage after deductible*
Outpatient Care		
▪ **Scheduled outpatient procedures**	100% coverage	70% coverage after deductible*
▪ **Outpatient Magnetic Resonance Imaging (MRI) and Computing Tomography (CT)**	80% coverage	70% coverage after deductible*
Emergency Care		
▪ **Urgently needed care at an urgent care Clinic or medical center**	$40 co-payment	80% coverage of 1st $2,500 then 100%
▪ **Emergency care at a hospital ER**	$55 co-payment	80% coverage of 1st $2,500 then 100%
▪ **Ambulance**	80% coverage	HealthPartners in-network benefit
Home Health Care		
▪ **Physical, speech, occupational, & respiratory therapy & home health aides**	$25 co-payment	70% coverage after deductible
Durable Medical Equipment		
▪ **Durable medical equipment & prosthetic devices**	80% coverage	70% coverage after deductible
Dental Care		
▪ **Treatment to restore damage done to sound, natural teeth as a result of accidental injury**	80% coverage	$50 deductible, then 80% coverage up to a $300 maximum
▪ **Preventive care for all ages, x-rays, exams, cleaning, fluoride treatment**	100% coverage	No coverage

* CareCheck® Service

*To receive maximum benefits for hospitalizations including medical emergencies and same-day surgeries outside the HealthPartners Network, you must notify CareCheck® at (952) 883-5800 or (800) 942-4872. A utilization management specialist will review your proposed treatment plan, determine length of stay, approve additional days when needed, and review the quality and appropriateness of the care you receive. Benefits will be reduced by twenty percent if CareCheck® is not notified. Please refer to a Group Membership Contract for further information.

Formulary Prescription Drugs (up to a 30-day supply; or 1 cycle of oral contraceptives; and up to a 90-day supply for mail order) Tobacco cessation products are limited to coverage in-network and a 180 day supply per year	**HealthPartners Participating Pharmacy Benefit**	**Non Participating Pharmacy Benefit**
▪ **Retail Pharmacy**		
▪ Generic	$10 co-payment	70% coverage after deductible
▪ Brand	$20 co-payment	70% coverage after deductible
▪ **HealthPartners Mail Order Pharmacy**		
▪ Generic	$20 co-payment - 3 month supply	
▪ Brand	$40 co-payment - 3 month supply	
▪ **Specialty Drugs**	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx benefit
▪ **Allergy injections**	100% coverage	70% coverage after deductible
▪ **Immunizations**	100% coverage	70% coverage after deductible

Three-Plan Comparison

The following page is a quick-reference, 3-plan comparison to assist you in identifying plan design differences. The list of benefits is a condensed version of the benefit summaries found in the previous section.

City of Saint Paul 2009 HealthPartners Plan Comparison

Health Service	Open Access Choice Plan with Deductible		Primary Clinic Choice Plan with Deductible		Distinctions	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime maximum	Unlimited	$1,000,000	Unlimited	$1,000,000	Unlimited	$1,000,000
Calendar Year Deductible (applies to Medical OOP Max)	$1,500 per person $2,500 per family	$2,000 per person $4,000 per family	$500 per person $1,000 per family	$750 per person $2,250 per family	None	$300 per person $900 per family
Calendar Year Out of Pocket Maximum (once OOP Max is met coverage is 100%)	$2,500 per person $2,500 per family	$3,000 per person $6,000 per family	$1,000 per person $1,000 per family	$1,500 per person $4,500 per family	$2,500 single $4,000 family	$2,500 per person $4,000 per family
Calendar Year Prescription Out-of-Pocket Maximum (once OOP Max is met coverage is 100%)	Combined with Medical Out-of-Pocket Maximum		$1,000 per person; $1,000 per family Combined in and out-of-network		$500 per person; $1,000 per family Combined in and out-of-network	
Preventive Health Care	100% Coverage	No Coverage	100% Coverage	No Coverage	100% Coverage	No Coverage
Office Visits Illness or Injury Physical Therapy Occupational Therapy Speech Therapy	80% after deductible	70% after deductible	80% after deductible	70% after deductible	$25 copay for Benefit Level 1 $40 copay for Benefit Level 2	70% after deductible
Chiropractic Services	80% after deductible	70% after deductible	80% after deductible	70% after deductible	$40 copayment	70% after deductible
Mental Health Chemical Health	80% after deductible	70% after deductible	80% after deductible	70% after deductible	$25 copayment	70% after deductible
Inpatient Hospital Care	80% after deductible	70% after deductible	80% after deductible	70% after deductible	100% coverage	70% after deductible
Outpatient Hospital Care	80% after deductible	70% after deductible	80% after deductible	70% after deductible	100% coverage	70% after deductible
MRI/CT	80% after deductible	70% after deductible	80% after deductible	70% after deductible	80% coverage	70% after deductible
Emergency Care Urgent Care Hospital ER Ambulance	80% after deductible	80% coverage after in-network deductible	80% after deductible	80% of first $2,500, then 100% 80% of first $2,500, then 100% HealthPartners in-network benefit	$40 copayment $55 copayment 80% coverage	80% of first $2,500, then 100% 80% of first $2,500, then 100% HealthPartners in-network benefit
Prescription Drugs	$10 generic formulary drugs $20 brand formulary drugs	70% after deductible	$10 generic formulary drugs $20 brand formulary drugs	70% after deductible	$10 generic formulary drugs $20 brand formulary drugs	70% after deductible
Specialty Drugs	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx Benefit	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx Benefit	80% coverage up to a $200 maximum per prescription per month	Out of Network Rx Benefit
Preventive Dental	100% Coverage	No Coverage	100% Coverage	No Coverage	100% Coverage	No Coverage
Special Oral Surgery	80% after deductible	70% after deductible	80% after deductible	70% after deductible	80% coverage	70% after deductible
Rates						
Single	$467.84		$575.43		$650.29	
Family	$1,222.84		$1,504.10		$1,699.76	

This is a general product comparison only. The products listed may not cover all of your health care expenses. For exact terms and conditions, refer to the Group Membership Contract to determine which expenses are covered.

Exclusions

Your health care plan does not cover all health care expenses. Below is a summary of items that are excluded or limited. Please refer to your Group Membership Contract for specific information about excluded services and supplies, or call HealthPartners Member Services at (952) 883-5000 or (800) 883-2177.

- Treatment, services, or procedures that are experimental, investigative, or not medically necessary
- Dental care or oral surgery*
- Non-rehabilitative chiropractic services
- Eyeglasses, contact lenses, hearing aids (over age 18) and their fittings
- Vocational rehabilitation; recreational or educational therapy
- Private-duty nursing; rest, respite, and custodial care*
- Physical, mental, or substance-abuse examinations done for, or ordered by third parties
- Sterilization reversal and artificial conception processes*
- Cosmetic surgery*

* Except as specifically described in the Group Membership Contract

In addition to the exclusions and limitations listed above, **out-of-network coverage also excludes preventive health care services**.

Utilization Management Programs

Part of helping HealthPartners members stay healthy is making sure they get the care they need when they need it. To help coordinate effective, accessible, and high quality health care, HealthPartners uses utilization management programs. These programs are based on the study of patient populations to evaluate appropriate levels of care. They use guidelines for the best medical practices based on the most up-to-date medical evidence.

HealthPartners' utilization management programs include activities to reduce the underuse, overuse, and misuse of health services. These programs include:

- Inpatient concurrent review and care coordination to ensure a safe and timely transition from the hospital to out-patient care
- Best practice for selected kinds of care
- Outpatient case management to provide care coordination
- The CareCheck program to coordinate out-of-network hospitalizations

Prior approval is required for a small number of services and procedures. Review prior approval information at *www.healthpartners.com* and/or call HealthPartners Member Services. Typically, your doctor will request this approval on your behalf. Decisions are based on coverage criteria that are posted on the web site and available from Member Services.

HealthPartners does not employ incentives that encourage barriers to care and service. HealthPartners rewards doctors who achieve the highest levels of quality and service to patients through its Partners in Quality Programs: Partners in Excellence and Partners in Progress. The Partners in Excellence program offers bonus awards to primary care and specialty clinics achieving exceptional results on specific quality, satisfaction, efficiency, and health information technology targets. Uniquely, clinical targets are comprehensive, rather than limited to only one or two measures per disease state. The Partners in Progress program integrates financial

incentives for quality improvement into provider contracts. Partners in Progress blends payment for quality and payment for process into market-based reimbursement rates for primary care providers, specialists, hospitals, retail pharmacies and physical therapy providers. Health plan payments are set aside and paid if providers meet their individual targets.

HealthPartners Ranks Highest in Quality

HealthPartners delivers the greatest cost, care and service. HealthPartners unique partnership with providers, employers and most importantly, members, allows them to actively connect members with health and wellness support, engage members in health care decisions and deliver the best care at the best cost.

HealthPartners success has been recognized by third party organizations. In fact, HealthPartners was awarded the 2006/2007 #1 customer care award for health plan satisfaction by the National Research Corporation.

HealthPartners achieves the highest quality scores in this market. Each year, the National Business Coalition on Health invites plans nationwide to participate in the eValue8 process to collect information on health plan quality, to guide purchase decisions, and to assess health plan performance. In both the HMO and PPO categories, HealthPartners outranked its competitors in nearly all evaluation areas. It's the fourth year in a row that HealthPartners has led the pack in quality care.

Disease Management Programs

HealthPartners offers its HealthPartners CareSpan℠ disease management programs that focus on people with chronic conditions. These programs proactively identify individuals who are at high risk for medical conditions and provide special personalized support to them in managing their conditions.

The HealthPartners CareSpan℠ program offers a unique health and medical management approach that improves your health and lowers your overall health care costs. **HealthPartners' CareSpan℠ disease and case management programs include care for the following conditions/diseases:**

- Asthma
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Depression and Alcohol Misuse Disorder
- Diabetes
- Healthy Pregnancy
- Heart failure
- Rare and Chronic Diseases:
  - Multiple SclerosisSickle Cell Disease
  - Parkinson's Disease
  - Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP)
  - Myasthenia Gravis
  - Systemic Lupus Erythematosus (SLE)
  - Dermatomyositis
  - Cystic Fibrosis
  - Hemophilia
  - Gaucher's Disease
  - Amyotrophic Lateral Sclerosis (ALS)
  - Rheumatoid Arthritis
  - Scleroderma
  - Polymyositis

Health and Wellness Programs

HealthPartners health improvement programs provide health and wellness services to members. HealthPartners offers programs that make it easy for you to improve your health. Health improvement programs come in a variety of formats and cover several topics, such as:

Frequent Fitness Program

Through the Frequent Fitness program, HealthPartners encourages you to work out to get – or stay – fit. Eligible members who join a Frequent Fitness participating facility and work out a minimum of 12 times per month qualify for reimbursement on monthly dues. Some participating facilities also reduce or waive their initial joiner's fee. View a complete list of participating clubs at *www.healthpartners.com.*

10,000 Steps® Program

Since 1999, HealthPartners has led the nation in increasing moderate physical activity by using novel, supportive messaging, and a step-counting pedometer. The 10,000 Steps program has made physical activity a lifestyle solution rather than a chore. In fact, in 2004, the U.S. Department of Health and Human Services selected HealthPartners' 10,000 Steps program as one of the best physical activity programs in the country.

Two versions of the innovative online program are available – the original *Feel Great Edition* and the new *Lose Weight Edition*. The *Lose Weight Edition* incorporates tools for self-management, including an innovative eating plan that assists participants with increasing physical activity to boost metabolism and decreasing calories while staying full.

Both editions include a pedometer, weekly e-mails providing effective day-to-day strategies to increase physical activity and lose weight, online tracking tools, and simple convenient meal ideas to help participants eat well. Both editions are available in online and mail-based versions.

Healthy Discounts

This expanding list of programs allows members – including those who can't or don't want to join a health club – to get discounts on tools and services to help you be as healthy as you can be. Simply show your HealthPartners Member ID card to participating retailers to receive Health Discounts on exercise equipment, classes, snowboard and ski equipment, spa and wellness services, and much more. Please note some programs may change throughout the year. For the most updated list, visit www.healthpartners.com, click on "Health Resources" then "Health Discounts."

- *Weight Watchers*
  - $10 off a three-month subscription to Weight Watchers Online. To learn more, visit: *www.weightwaters.com/cs/healthpartners*.
  - A $10 discount on At-Home kits.
  - Local meeting discount coupons on weekly meeting fee and waived registration fee.
- *Eyewear*
  - Enjoy the convenience of one-stop optical shopping at HealthPartners Eye Care Centers, featuring a wide selection of contacts, stylish frames, and lenses to fit every budget – with savings of up to 35% on eyewear.
  - Savings of 10-20% on eyewear at more than 60 providers throughout the HealthPartners vision network.
  - Save up to 35% on eyeglasses, plus get great deals on contact lenses and more at thousands of independent and optical retailers like LensCrafters®, Pearle Vision®, and optical centers at Sears, Target, and JCPenney.
- *Orthodontic Care Specialists*
  - HealthPartners Dental Members of all ages receive a 20% discount whether you have orthodontic coverage or not.
  - Available at 19 locations; visit www.orthodonticare.com for locations and details – available for Health Partners Dental policy holders only.
- *Safe beginnings®*
  - Get a 20% discount on products from Safe Beginnings – choose from a large selection of items to keep your baby safe (some exclusions may apply).
  - To order, visit www.safebeginnings.com and enter code HPW or call (800) 598-8911 for a catalog and identify yourself as a HealthPartners member when you order.
- *Penn Cycle & Fitness*
  - HealthPartners members get 10% off the regular price of any bike accessories or clothing, and $15 off the regular price on bike tune-ups.
- *Erik's Bike Shop*
  - 10% off all snowboards and snowboard-related accessories, parts, and clothing.
- *Professional Karate Studios*
  - $10 per month off any regularly priced program.
  - Participating Minnesota locations are Blaine, Cambridge, Coon Rapids, Elk River, and Rogers.

- *2nd Wind Exercise Equipment*
  - HealthPartners members get the maximum discount available on exercise equipment at every 2nd Wind store (does not include spas or spa accessories).
  - HealthPartners members are also eligible for one free in-home personal training session with purchase of $500 or more (for members with home addresses in Twin Cities and other select locations).
- *Hoigaard's*
  - Discounts on the following:
    - 10% off recreational kayaks and heart rate monitors.
    - 15% off Camelback® hydration systems, cross country skis, and ski equipment.
    - 20% off a ski, snowboard, or bicycle tune-up.
- *Solimar Wellness Spa*
  - Full-service wellness, health and day spa providing services that support health and healing for body, mind, and spirit. Go to *www.healthpartners.com* for participation instructions.
  - A variety of discounts are available on different services, including spa services, classes and special events, wig consultations and services, and more.
- *Albertville Premium Outlets*
  - Obtain a free Albertville Premium Outlet® VIP Coupon Book ($5 value).
  - Contains discounts at a variety of Albertville Premium Outlet stores, including those with workout gear and athletic shoes.
- *Seattle Sutton's*
  - Seattle Sutton's is a meal delivery/pick up service that provides fresh, healthy foods to individuals who want to lose weight and eat healthy. With HealthPartners, local members in Minnesota or western Wisconsin receive $5 off per week.
  - Nationally, members can receive $100 off after 25 consecutive weeks in the program ($4 off per week).

Phone Based Programs

HealthPartners Phone Based Programs offer an individualized approach to meet each participant's needs with health coaching by phone. Choose from nine award-winning courses staffed by registered dieticians, health educators, exercise specialists, and pharmacists – all with behavior change experience. There is a fee to take most of the phone course. For more information on the courses or prices, or to enroll, please call HealthPartners Health Promotion department at 952-967-5123 or 1-866-977-5123.

- *Smoking Cessation*
  - **A Call to Change…Partners in Quitting®,** includes individualized phone counseling sessions with a Health Educator to prepare and help individuals through the process of quitting.
- *Healthy Pregnancy*
  - **A Call to Change…Healthy Choices, Healthy Baby℠** is designed to help participants make lifestyle choices for a healthy pregnancy.
- *Back Pain*
  - **A Call to Change…Back to Health℠** helps participants prevent or manage back pain.

- *Healthy Weight*
  - **A Call to Change…Healthy Lifestyles, Healthy Weight℠** supports participants in designing a personal action plan to successfully manage their weight.
- *Stress Management*
  - **A Call to Change…Balancing Stress for Health Living®** provides steps for time management, positive thinking, relaxation, and meditation.
- *Cholesterol Management*
  - **A Call to Change…Solutions for High Cholesterol℠** shares information on cholesterol-lowering medications, eating to improve cholesterol levels, and physical activity.
- *High Blood Pressure*
  - **A Call to Change…Solutions for High Blood Pressure℠** helps participants understand medication management, healthy eating, and physical activity.
- *Getting Active*
  - **A Call to Change… Get Moving, Get Fit℠** helps participants increase regularity of physical activity, boost overall fitness, enhance flexibility, and discover the benefits of strength training.
- *Healthy Eating*
  - **A Call to Change… Healthy Eating, Healthy Life℠** supports establishing healthy eating for life. Registered dieticians help participants understand balanced eating, plan healthy meals, read food labels, learn how to grocery shop and snack healthy.
- *Managing Diabetes*
  - **A Call to Change… Balancing Life with Diabetes℠** helps participants understand how to best manage diabetes and develop a healthy lifestyle.
- *Managing Hear Disease*
  - **A Call to Change… Living Well with Heart Disease℠** helps participants develop healthy habits and strategies to living with heart disease.

Service Area

The HealthPartners areas of service and networks of medical providers continues to grow, but access to all provider types is not guaranteed. Contact HealthPartners Member Services at (952) 883-5000 or (800)-883-2177 for current lists.

Improved Access for Appointments, Direct Access to Providers

HealthPartners Clinics offer same-day appointments. Members may call seven days a week to schedule an appointment at a HealthPartners Clinic or may schedule an appointment online. In addition, HealthPartners members who are enrolled in a primary clinic do not need a referral to see a specialist within their plan network.

Provider Reimbursement

HealthPartners' goal in reimbursing providers is to provide affordable care for members while encouraging best care practices and rewarding providers for meeting the needs of its members. HealthPartners has several different kinds of reimbursement arrangements with its providers.

Providers can be paid on a **fee-for-service** basis, which means that the health plan pays the provider a certain set amount that corresponds to each type of service furnished by the provider.

HealthPartners has **case rate** arrangements with certain providers, which means that for a selected set of services the provider receives a set fee, or a "case rate," for services needed up to an agreed upon maximum amount of services for a designated period of time. Alternatively, HealthPartners may pay a "case rate" to a provider for all of the selected set of services needed during an agreed upon period of time.

HealthPartners has **withhold** arrangements with some providers, which means that a portion of the provider's payment is set aside. Payment of the withhold pool is dependant on the provider's success in meeting quality goals. The goals can include implementation of new protocols to insure quality care for specific conditions, increasing the use of appropriate cost effective medications, and increased use of electronic tools that promote safer care.

Some providers – usually hospitals – are paid on the basis of the diagnosis that they are treating; in other words, they are paid a set fee to treat certain kinds of conditions. Sometimes HealthPartners pays hospitals and other institutional providers a set fee, or **per diem**, according to the number of days the patient spent in the facility.

HealthPartners reimbursement arrangements with providers can include a combination of the methods described above. In addition, although HealthPartners may pay a provider such as a medical clinic using one type of reimbursement method, that clinic may pay its employed providers using another reimbursement method.

HealthPartners' Approach to Protecting Personal Information

As a health plan, HealthPartners complies with federal and state laws regarding the confidentiality of medical records and personal information about members and former members. They have developed policies and procedures to ensure that the collection, use, and disclosure of such information comply with the law. Whenever necessary, HealthPartners obtains consent or authorization from members, or an approved member representative when the member is unable to give consent or authorization, for disclosure of personal information.

HealthPartners gives members access to their own information consistent with applicable law and standards. HealthPartners policies and practices are designed to facilitate appropriate and effective use of information, internally and externally, to enable them to serve members and improve the health of their members, patients, and the community, while being sensitive to their privacy. If you would like to receive a copy of HealthPartners privacy notice, please visit *www.healthpartners.com* or call Member Services at (952) 883-5000 or (800) 883-2177. For your provider's privacy policy, please contact your provider directly.

Take Your HealthPartners Coverage Wherever You Go

If you're planning to travel outside Minnesota, HealthPartners will travel with you. All HealthPartners members who travel outside of Minnesota have access to the extensive CIGNA HealthCare network of health care providers. The network consists of more than 565,000 medical providers and 5,000 hospitals across the country, all of which have met CIGNA provider-credentialing standards.

Except the HealthPartners Open Access Choice with Deductible Plan, out-of-network benefits apply when a HealthPartners member receives services from a CIGNA provider. However, the member's portion of the bill is based off a discounted amount, resulting in lower out-of-pocket costs. HealthPartners' member identification cards (ID cards) identify that the CIGNA providers are available out-of-network. In the HealthPartners Open Access Choice with Deductible Plan, services received from a CIGNA provider are covered at the in-network level.

For information about CIGNA providers, members can access the HealthPartners web site at www.healthpartners.com or call Member Services at (952) 883-5000 or (800) 883-2177. Look for the CIGNA number on the back of your new member ID card that will be mailed to you by January 1, 2009. Please note that the CIGNA network arrangement does not change your health plan's benefits; please see your Group Membership Contract for benefit details.

Claim Forms

When you receive health services from a HealthPartners network provider, the provider submits the claim for you. When you receive health services from out-of-network providers, you must complete a claim form and submit it to HealthPartners for reimbursement. Details regarding reimbursement are described in the Group Membership Contracts. You can request additional claim forms from HealthPartners Member Services at (952) 883-5000 or (800) 883-2177.

Prior Authorization Through CareCheck

The CareCheck program is a precertification and utilization management program for members using out-of-network providers for hospitalization services.

To assure that you receive cost-effective, medically appropriate care when using an out-of-network provider, you must notify HealthPartners in advance whenever hospitalization or surgery is arranged. HealthPartners staff will evaluate and advise you of the medical necessity of the hospitalization or surgery; the extent of benefit coverage you can expect; and care alternatives that may maximize your benefits.

If you are hospitalized or require surgery out-of-network and do not call CareCheck for prior authorization, benefits will be reduced. Please check your Group Membership Contract for more information about prior authorization through the CareCheck program. If you are using a HealthPartners network provider, it is not necessary to call CareCheck.

You can call CareCheck 24 hours a day. For members living in the metro area, the number is (952) 883-5800. Members living outside the metro area call toll-free at (800) 942-4872.

Dental Coverage

The HealthPartners dental plan covers preventive dental visits with dentists in the HealthPartners Network. This benefit is available for all members on the health insurance plan. There is no co-payment required for preventive dental services – coverage is 100%. Preventive dental services include:

- Examination of mouth and teeth
- Cleaning and polishing of teeth
- Oral hygiene instructions
- Professionally applied fluoride treatments
- X-rays

You can find a list of dentists participating in the HealthPartners network online at *www.healthpartners.com* and in the HealthPartners Dental Network directory. You may pick up a CD-ROM directory at any open enrollment or you can request a directory by calling HealthPartners Member Services at (952) 883-5000, toll-free at (800) 883-2177, or at (952) 883-5127 for the hearing impaired.

In addition to this benefit, the HealthPartners Dental Distinctions optional dental plan is available to employees. Please see additional information about this plan on page 51.

Member Phone Support 24/7

CareLine℠ Nurse Line

The HealthPartners CareLine Nurse Line is a free, after-hours phone service staffed by registered nurses to answer members' health questions. CareLine nurses assess the caller's condition and discuss the most appropriate care options – whether it's an emergency room, urgent care visit, or self-care at home. Members find it reassuring to have an expert to call who can advise them. Call CareLine at (612) 339-3663, or toll-free at (800) 551-0859 if you are outside the metro area. If you are hearing impaired, call (952) 883-5474, or toll-free at (800) 983-5474.

Nurse Navigators℠ Program

For more complex health issues, HealthPartners registered Nurse Navigators can help members sort through care, benefits, and provider issues. They also guide members to important services and information that can help them get the most from their treatment and coverage. Nurse Navigators are available through Member Services.

BabyLine Service

The HealthPartners BabyLine service is a special phone line that provides support for expectant parents and new parents up to six weeks post-partum. Call (612) 333-BABY (2229) or (800) 845-9297 to speak with ObGyn nurses about pregnancy, new baby care, nursing, and post-partum issues.

Behavioral Health Personalized Assistance Line (PAL)

You may need help in recognizing behavioral health needs or finding the appropriate provider. Simply call the Behavioral Health Personalized Assistance Line (PAL) at (952) 883-5811 or toll-free at (888) 638-8787 and PAL staff can match you with the network provider that best meets your behavioral health needs. Providers can be identified based on:

- Specialty or subspecialty
- Specific diagnostic, language, and cultural competence

If you have an urgent need, PAL staff can link you to same day/next day psychiatric appointments.

Member Services

HealthPartners Member Services representatives are ready to answer your questions about HealthPartners plans and providers. These trained staff members can answer administrative questions and help with inquiries about benefits, claims, and more. The Member Services number is (952) 883-5000, or toll-free (800) 883-2177. People with a hearing impairment may call (952) 883-5127. Member Services representatives are available to assist you Monday through Friday from 7:30 a.m. to 6:00 p.m., Central time.

HealthPartners has expanded Member Services offerings to include face-to-face support; extended hours by appointment; internet access through secure web mail; the ability to work with the same Member Services representative each time help is needed; and specially trained Nurse Navigators who can explain medical terminology, coverage, and care guidelines.

If you have an inquiry or concern, you should call HealthPartners Member Services at (952) 883-5000 or (800) 883-2177. A Member Services representative will work with you to respond to questions and attempt to resolve any concerns or complaints. If a mutually agreeable resolution cannot be reached and you wish to pursue the issue further, you may file an appeal.

If you want to appeal a decision made by HealthPartners, you must notify the Member Services Department in writing. Member Services will provide you with detailed information on how you may pursue the appeals process. Additional appeal information can be found at *http://www.healthpartners.com/portal/225.html*.

Website

You have a secure, personal website at *http://www.healthpartners.com/*. Through HealthPartners secure site, you have instant access to detailed information and helpful services tailored to you. Depending on your specific coverage, you may:

- View your medical provider network
- View your benefits
- Order new ID cards
- Refill mail order prescriptions
- View claims history and benefit accumulators including claims status and explanation of benefits
- Refill mail order medications and prescriptions at HealthPartners pharmacies
- Schedule an appointment at a Health Partners Clinic
- Apply to enroll in disease management programs
- Contact member services with questions and concerns

- Use the "Ask an Expert" feature to get answers to medical questions
- Establish a personal health record to manage health-related activities
- Receive confidential medical information from HealthPartners in a secure mailbox
- Use MyChart to get test results online, schedule a doctor's appointment, request an appointment from a specialist or look up immunization records for you or a family member

HealthPartners Clinics offer the only **online appointment scheduling service** in the Twin Cities that allows patients to select their provider of choice, appointment time and date, and actually book their HealthPartners Clinic appointment online directly through HealthPartners secure website.

Medical Cost Calculator
To help you learn more about the cost of your care, HealthPartners offers online access to their Medical Cost Calculator. The medical cost calculator gives you personalized health care cost estimates based on current health care expenses in Minnesota. You can estimate your annual cost of care, get a detailed estimate of costs for chronic health concerns, and estimate costs with or without prescription drug costs.

Pharmacy and Co-pay Cost Calculator
HealthPartners' Drug Cost Calculator allows you to look up a specific drug and determine the cost for that drug based on your actual pharmacy benefit. The Drug Cost Calculator also calculates and displays the cost for therapeutically equivalent and generic drugs that are less expensive than the brand name drug. You can then email or print the results for future reference. If you do not have internet access, you may call HealthPartners Member Services Department to obtain this information.

Clinic and Provider Information
As always, the HealthPartners website will help you make informed decisions about clinics and providers.

Clinic Information
- Clinic hours
- Locations, including directions
- Providers
- Hospitals and key specialists
- Open/closed to new patients

Provider Information
- Practice specialty
- Credentials
- Personal profiles (some even include photos)

Comparative Data
- Quality of care measures
- Consumer satisfaction survey results

Plan Information
- Plan-wide programs and services, including member discounts, health improvement programs, and health education classes
- Member information, including member handbooks, consumer rights, and quality improvement

Coverage Policies
As part of HealthPartners commitment to "no secrets, no surprises" for members, HealthPartners publishes the coverage guidelines that let members know in advance if a particular service is covered.

HealthPartners Formulary
You can quickly and easily see all of the medications on the HealthPartners formulary. You can search by drug name (either brand or generic) or by type of drug (e.g., antibiotics).

eCare – Internet Health Care Services
eCare is the latest in HealthPartners use of technology to improve and enhance patient care. In 2005, the HealthPartners Clinics began piloting eCare, a secure set of internet health care services, including:

- Direct access to test results
- Medication history
- Allergy history
- Active conditions
- Immunization history
- After-visit summaries

In addition, patients are able to request advice for non-urgent medication conditions and update their address and insurance information. **eCare is now available for all HealthPartners Clinics' members.**

Employee Assistance Program

Because personal, legal, and financial problems can decrease on-the-job productivity, HealthPartners provides a telephonic and online employee assistance program (EAP). HealthPartners EAP is a confidential assessment, counseling, and referral service to help you resolve personal or work-related problems including relationships, mental health, legal troubles, domestic issues, substance abuse, gambling, financial concerns, or work concerns. It's available online at *hpeap.com* (Employer ID: healthpartners, Password: saintpaul) or by phone for employees and their families at no cost, 24 hours a day, seven days a week. Professional counselors are a toll-free phone call away at (866) 326-7194 or (800)-827-3707 for the hearing impaired.

In addition, HealthPartners EAP offers culturally diverse services. For example, callers may speak with Spanish-speaking counselors, and website content is available in English and Spanish.

HealthPartners EAP also offers assistance for managers and supervisors to get information and support for dealing with personnel concerns. HealthPartners EAP complements the City's internal resolution processes with an objective third-party perspective – without replacing or infringing upon personnel policies or procedures.

CAFETERIA PLAN AND FLEXIBLE SPENDING ACCOUNTS

PLAN OVERVIEW

The City of Saint Paul cafeteria plan allows eligible employees to save tax dollars by deducting their contributions to the qualified plans with pre-tax dollars, thereby reducing your taxes and increasing your take home pay.

If you are benefits eligible, you can set aside up to $4,000 each year for payment of certain health care expenses, $5,000 (total for both husband and wife) each year for payment of certain dependent care expenses (daycare) and $220 per month for your parking expenses. Pre-tax payroll deductions and contributions to these accounts are not subject to federal, state, or social security taxes.

A summary of the cafeteria plan and flexible spending account features are on the following pages. The formal plan document controls the operation of the plan in all circumstances. A Summary Plan Description is available on the Knowledge Base in Benefit*Ready* and on the City of Saint Paul web site at:

http://www.stpaul.gov/benefits

FSA Administrator

Outsource*One* administers the flexible spending accounts and transportation accounts for the City of Saint Paul.

Effective Dates

The cafeteria plan and flexible spending accounts became effective January 1, 1989. The transportation account became effective July 1, 2004. The accounts operate on a "plan year" that always ends on December 31. A new plan year will begin on January 1 and will run through December 31. You must enroll during the annual open enrollment, prior to the beginning of each plan year, for benefits and expenses that will be incurred during the plan year or period of coverage.

Eligibility

All employees of the City of Saint Paul who have met the eligibility requirements for the City-sponsored insurance plan may participate as of their effective date.

For subsequent plan year enrollments, an employee must be actively at work on the first day of the plan year. If the employee is not actively at work on January 1, participation will be delayed until the employee is actively at work.

If you do not enroll when you are first eligible, federal regulations require that you must wait until the following plan year (January 1) to participate. However, the plan provides that some qualifying events may allow you to make an election change. All changes must be consistent with the event as required by the IRS. The following events would permit a mid-year change to your health, dental insurance plan, and/or your flexible spending account election:

- Change in marital status (marriage/divorce/legal separation/annulment)
- Change in number of employee's dependents (birth/adoption/death)
- Employment status change for you, your spouse, or your dependent (strike/lockout/ termination or commencement of employment/full time to part time or vice versa)
- Dependent eligibility (attainment of policy maximum age/marriage).

The above examples are not comprehensive. If you have a question regarding status changes, please contact Risk Management at (651) 266-6500.

In addition, you must re-enroll during the annual open enrollment for each subsequent plan year in which you wish to participate. Your current elections do not carry forward to future plan years. An election to participate is valid for only one plan year (January 1 - December 31).

Accounts Available

There are four ways in which you can save money with the City of Saint Paul cafeteria plan:

- **Pre-Tax Premiums:** When you are eligible and enroll in the City-sponsored health and/or dental plan, the premium costs that you are responsible for will be deducted from your paycheck before taxes are taken out.
- **Health Care Account:** When you enroll in this account, you must decide how many of your payroll dollars (not to exceed $4000 annually) for the plan year will be directed to this account to pay, on a pre-tax basis, for eligible health care expenses that would otherwise be paid out of your pocket on an after-tax basis. Examples of expenses that are eligible are listed on page 35.
- **Dependent Care Account:** When you enroll in this account, you decide how many of your payroll dollars (not to exceed $5000 annually) will go into this account to pay, on a pre-tax basis, for eligible dependent care (daycare) expenses while you are at work and your spouse is at work/school/seeking work. See page 40 for more information.
- **Transportation Account:** When you enroll in this account, you decide how many payroll dollars (not to exceed $220 monthly for parking) will go into this account to pay, on a pre-tax basis, for eligible parking expenses while you are at work. See page 43 for more information

Amounts deposited in one account cannot be used to reimburse expenses from the other accounts; money cannot be commingled. The funds you elect to contribute to the health care account, dependent (daycare) care account and transportation account will be set aside pro-rata from 24 of your paychecks each year (the first two paychecks per month).

Administrative Fee

No administrative fees will be charged to employees who participate in the health care account, dependent care account and/or transportation account.

Enrollment Procedures
Elect participation in all Flexible Spending Accounts using the Benefit*Ready* system. Outsource*One* representatives will be available at open enrollment information sessions to assist you in determining appropriate election amounts.

For 2009 the City of Saint Paul will contribute $100/month into a medical flexible spending account (FSA) for eligible employees who elect the HealthPartners Open Access with Deductible medical plan, single coverage. To receive this contribution, the employee must enroll online during Open Enrollment or within 45 days of hire date for new employees in the 2009 Employer FSA plan on the Benefit*Ready* system. Eligible employees may elect up to $1200 (depending on employment status, employee group and benefits eligibility date). Employees may also elect to have pre-tax deductions from their paycheck for the Medical Expense FSA 09 plan. The total election for both the Employer FSA and the Medical Expense FSA cannot exceed $4000.

Forfeitures
According to federal law, any funds remaining in your health care and dependent care accounts after the payment of eligible expenses incurred during a plan year will be **forfeited**. You must submit any reimbursement requests for expenses incurred through your period of coverage for the prior year in order to be reimbursed from the prior year's contributions. **Reimbursement requests for medical and daycare must be received at Outsource*One* by February 16, 2009, 4:30 PM CST, for eligible expenses incurred during the 2008 plan year.**

Reimbursement requests must be received by Outsource*One* by January 30, 2009, 4:30 PM CST, for transit expenses incurred in the 2008 plan year. Remaining balances will be rolled over to the 2009 plan year providing you enroll in the transit flexible spending account for 2009.

Budgeting your accounts carefully should help you to avoid forfeitures. Even if you do incur forfeiture, you still may be money ahead. For example, if you would otherwise pay a total of 30% in federal, state, and social security taxes, you could save 30% on any expenses you pay with pre-tax dollars through these accounts. Therefore, if you deposit $1,000 into your account and you forfeit $100, you're still $200 ahead because you've saved approximately $300 in taxes.

Disclaimer
If you have questions regarding the eligibility of a particular expense, resources that can be of assistance are IRS publications 502 and 503 (for health care and dependent care expenses, respectively) and are accessible through the IRS website at *www.irs.gov*, the library, or your tax advisor.

Please note that Outsource*One* and the City do not provide tax advice to participants. Provisions for the health care, dependent care and transportation accounts make every attempt to follow the same rules used by the IRS with respect to health care, dependent care, and transportation expenses. Unfortunately, some types of expenses are not clearly identified by the IRS and, in those instances, you should check with the above resources before you enroll in these accounts to determine if your particular expense will be reimbursable.

The City of Saint Paul can make no guarantee that the provisions of these accounts will not be changed due to federal or state laws, or that it will not be amended or withdrawn at some future date.

Tax savings
The chart on the following page illustrates possible tax savings using a dependent care account.

POSSIBLE TAX SAVINGS

ONE DEPENDENT

Federal Tax Credit for 2007		Dependent Care	
$3,000	Available Amount	$5,000	Maximum Contribution
x 20%	Credit for incomes exceeding $43,000	x 34.65%	Federal, Social Security
$600	Federal Tax Credit	$1,732.50	Tax Savings*

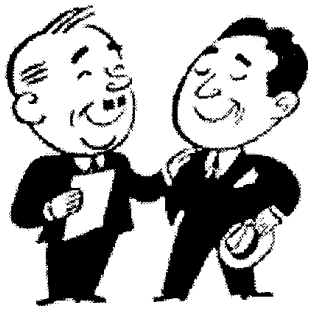
$1,132.50 increase in spendable income using the FSA

*Actual savings are proportional to your tax bracket

Estimated Impact on Social Security
Your social security benefits could be affected if your taxable earnings are less than the social security maximum covered wages ($102,000 in 2008). The laws affecting social security taxes and benefits are constantly changing, so there is really no way to predict how anyone might be affected. The decision becomes one of whether the current overall tax savings are more valuable to you than a possible reduction in social security benefits in the future.

Impact on PERA and Other Benefits
Your PERA contributions and benefits will continue to be based on your gross pay (total wages) before deductions), so they would not be reduced if you participate in the cafeteria plan or flexible spending accounts. In addition, benefits from other City pay-related benefit plans are based on your gross pay without regard to any salary conversion amounts.

If you have questions about Flexible Spending Accounts, you can meet with an Outsource*One* representative at any of the information sessions.



HEALTH CARE ACCOUNT

Qualifying Expenses
Health care account expenses that qualify for pre-tax reimbursement include any medical or medically-related expense including over-the-counter medications (up to $4,000 per plan year). This includes expenses for you and your family that are eligible but are not taken as a deduction on your income tax form, and **only** if you are **not** reimbursed for the expense from any other source. Premiums for insurance are not eligible for pre-tax reimbursement under this account. In addition, cosmetic surgery and other elective procedures are not reimbursable under this account unless medically necessary to correct a congenital abnormality or a deformity arising from injury or accident.

Some examples of expenses that can be paid on a pre-tax basis from your health care account are:

- Dental, mental health, or chemical dependency co-payments
- Chiropractic services
- Prescription drugs (including co-payments)
- Mental/nervous disorders
- Dental expenses (non-cosmetic)
- Orthodontia (*Special rules apply. See page 36 & 37.)
- Medical equipment
- Smoking cessation programs
- Assistance for persons with disabilities
- Over-the-counter medications (specifically to treat illness, injury, or disease)
- Vision care, prescription eye glasses, contact lenses, contact lens solution, or laser surgery
- Chemical dependency services
- Ambulance service
- Medically-related transportation
- Nursing care
- Hearing aids
- Psychiatric care (excludes group/marriage counseling)
- Deductibles, co-payments, and co-insurance from your health insurance plan
- Insulin pump and diabetic supplies

IRS regulations govern the eligibility of expenses, which include those that are not fully covered by a health care plan and are prescribed by a physician or other licensed professional primarily for the purpose of preventing, treating, or mitigating a defect or illness. IRS Publication 502 contains guidance on eligible and ineligible medical, vision, or dental expenses that may be claimed on your Individual Income Tax. Most of the information contained in the IRS Publication 502 may apply to reimbursement regulations for your Flexible Spending Account. Outsource*One* can assist you in determining whether a specific expense is reimbursable under your Flexible Spending Account. You should always confirm that any contemplated medical expenses are reimbursable **before** you sign up for this account. A more detailed list of eligible/ineligible expenses is available of Benefit*Ready*, Help, Knowledge Base.

ORTHODONTIA EXPENSES AND FLEXIBLE SPENDING ACCOUNT REIMBURSEMENT

Orthodontia is a covered medical expense, but it can be tricky because of the extended nature of the treatment and the manner in which fees are paid. We strongly encourage any participant with questions to call us before beginning treatment at (612) 436-2778.

The basic Internal Revenue Service rules for reimbursement of eligible expenses through a Flexible Spending Account state:

1) An individual may only be reimbursed for expenses incurred while a participant is in the plan.

2) An expense is incurred when the service is performed (**not** when it is billed or paid).

3) The participant must submit documentation showing that the expense has been incurred (service has been provided).

4) The expense must be reimbursed from funds allocated for the plan year in which the expense was incurred. Expenses or unused funds cannot be carried over to a different plan year.

Orthodontic treatment is usually provided over an extended period of time, with an initial examination and installation, and monthly adjustments. The services are often paid for over an extended period of time, with an initial down payment, and monthly payments over the life of the contract.

There have been extensive conversations with the IRS on how orthodontic expenses are to be reimbursed. Their basic rule still applies in that expenses may only be reimbursed after they have been incurred, which means after the actual service has been provided. They have stipulated, however, that if the orthodontia fee payment schedule is a reasonable approximation, in both time and dollars, of the actual costs and services provided over the duration of treatment, then we may reimburse for the initial down payment and for the monthly charges as each payment is made according to the fee schedule. The participant, therefore, has two ways to submit documentation in order to be reimbursed, either on a "services provided" basis or on a "fee payment schedule" basis.

The first method is the same as any other medical expense and requires the participant to submit a statement from the orthodontist showing that a service has been provided and stating the cost of that service.

The second method allows the participant to submit proof that payment has been made at the required time called for by the payment schedule. The participant MUST submit a treatment plan from the orthodontist, including the total cost of the treatment, the expected length of the treatment, the down payment amount, and the monthly fee to be reimbursed. For example, suppose the total cost of treatment is $3000, is expected to last 24 months, and the contract calls for a down payment of $600 and a monthly charge of $100 for 24 months. We will reimburse the $600 upon receipt of documentation showing that the initial service has been provided and

payment has been made. We will reimburse $100 per month upon receipt of documentation showing that the monthly payment has been made. This documentation could either be a receipt from the orthodontist showing that payment has been received for the current month's scheduled charge, or a photocopy of the current month's payment coupon and the participant's personal check.

Notes:

- You cannot pre-pay for services and be reimbursed at the time of that payment. You can only be reimbursed as services are provided. If a total payment is made up front for the treatment, the participant still must submit a treatment plan and the payments will be disbursed over the course of the length of treatment. Down payments for orthodontic are reimbursed at 20%.

- If you decide to pay off the contract early while the treatment is still continuing you can only be reimbursed as services are provided.

- If the treatment is completed sooner than expected and you decide to pay off the remainder of the contract early you can be reimbursed for that payment because the services are complete.

Why does the IRS make these rules regarding payment of orthodontic claims?

The IRS is actually protecting the employer group by placing these guidelines on orthodontic claims. For example, an employee elects $4000 for medical flex for 2009 and is paid out the entire $4000 for his/her child’s orthodontia in February of 2009. The employee leaves the company on March 1, 2009. The employer group is responsible for the $4000 even though the employee did not have $4000 deducted from their paycheck. The orthodontic services have not really been rendered yet, so the employer group is paying for orthodontic services that will be rendered after the employee has left the company. Although medical flex always poses a risk for employer groups, orthodontia is unique in that the services are rendered over a period of time. Most other medical or dental expenses are incurred at the time of the expense and less of a risk of paying for expenses that are incurred after an employee terminates, or in a plan year that the employee does not elect a flexible spending account.

Reimbursement for Health Care Expenses

When you incur an eligible health care expense and submit the claim to the plan's administrator, Outsource*One*, the expense will be reimbursed on a regular basis. The plan will pay the lesser of:

- The amount of the expense you are submitting; or
- The total amount you have elected to contribute to the plan for the year, reduced by any previous claims you have made during the plan year.

Expenses incurred during one year cannot be reimbursed with money contributed in a prior or subsequent year, nor can expenses incurred prior to the inception of the health care account be paid. Only the eligible expenses you incurred while you were a participant in the health care account can be reimbursed with pre-tax dollars you contributed. Reimbursements are eligible based on when services are incurred, not when you pay for services (this applies to orthodontic; see insert on Orthodontic, pages 36 and 37). All requests for reimbursement for expenses incurred in a plan year must be submitted by **February 16th 4:30 PM CST** following the plan year.

Qualifying Status Changes

The plan provides that a change to your election may be allowed mid-plan year under certain circumstances in which the family's status has been affected. All changes must be reported to Risk Management within 30 days of the event. All changes must be consistent with the event as required by the IRS. The following events would allow a mid-year change to your healthcare election:

- Change in marital status (marriage/divorce)
- Change in number of employee's dependents (birth/adoption/death)
- Change in employment status of employee or employee spouse. Includes strike, lockout, termination of employment, or gaining employment.

The above examples are not comprehensive. If you have any questions regarding status changes, please contact Risk Management at (651) 266-6500.

Termination of Employment

If you terminate employment during the year, your period of coverage under the health care account will cease the end of the month in which your last payroll deduction is taken. Expenses incurred prior to your date of cancellation can be submitted throughout the remainder of the plan year. However, expenses incurred after your date of cancellation cannot be paid from this account. You **may** be allowed to continue your participation in the health care account (if qualified) by electing COBRA continuation coverage through the remainder of the plan year (see page 69).

Qualified Medical Child Support Orders

In certain circumstances, you may be able to enroll a child of a participant in the plan in the medical expense reimbursement portion of the plan by filing a **Qualified Medical Child Support Order** (QMCSO) with the employer. A QMCSO may only be filed with respect to a child of a participant of the plan. If you are interested in more information and the procedures for filing, please contact Risk Management at (651) 266-6500.

Tax Considerations

Generally, paying for uninsured medical and dental expenses through the health care account is more advantageous than deducting those expenses on your income tax form. Only your uninsured medical and dental expenses **in excess** of 7.5% of your adjusted gross income are deductible on your income tax form. However, under the health care account, all of your uninsured medical and dental expenses can be **paid for** with pre-tax dollars. Plus, under current law, you don't pay social security tax on amounts used to pay for these expenses through your health care account. Neither OutsourceOne nor the City of Saint Paul is permitted to give advice about personal income tax matters. You should consult your own tax advisor to help you determine if using the pre-tax health care account is advantageous for you.

DEPENDENT CARE ACCOUNT

Qualifying Expenses

Dependent care expenses that qualify for reimbursement must be necessary in order to permit you to be gainfully employed. If you are married, your spouse must be working in a job for pay outside your home, actively seeking employment, be a full-time student, or be physically or mentally unable to care for him or herself.

The following list outlines ALLOWABLE dependent care expenses:

- Provider caring for an individual in the employee's home
- Family daycare provider in the home of the provider (Licensed or Unlicensed)
- Daycare centers that comply with state and local laws
- Before/After school care programs
- Pre-school programs (for custodial purposes only)
- Church daycare programs
- Day Camps (for custodial purposes only)
- Sick-child facilities

The following list outlines dependent care expenses that are NOT ALLOWABLE:

- Educational expenses, including Kindergarten
- Overnight Camps
- Fees charged for field trips, meals, or activities.
- Transportation expenses
- Nursing home expenses
- Care provided by employee's child who is under the age of 19 or by employee's dependent.

Expenses incurred during one year cannot be reimbursed with money contributed in a prior or subsequent year, nor can expenses incurred prior to the inception of the account be paid. Only the eligible expenses you incur while you are a dependent care account participant can be reimbursed with the pre-tax dollars you contribute.

The calendar year maximum is $5,000 in dependent care expenses for one or more dependents. If you are married, and you and your spouse file separate federal income tax returns, not more than $2,500 of dependent care expense reimbursements for services provided during the year is exempt from tax. Any excess must be declared on your tax form as taxable income, and you must notify Risk Management at (651) 266-6500 of the excess.

If you are married, reimbursements from your dependent care account exceeding the earnings of the lower paid spouse for the year must be reported as taxable income for that year. For example, if you receive $3,600 of dependent care reimbursements for expenses for services provided during a year, and your spouse earned only $3,000 that year, the $600 excess must be declared as taxable income. You must notify the IRS as well as Risk Management at (651) 266-6500 of any such excess.

In order to have your dependent care expenses reimbursed on a tax-exempt basis from this account, you will have to furnish the name, address, and taxpayer identification number of your provider to the IRS on your federal income tax form.

Reimbursement for Dependent Care Expenses

When you incur an eligible dependent care expense and submit the claim to the plan's administrator, Outsource*One*, the expense will be reimbursed from your account on a regular basis. The plan will pay the lesser of:

- The amount of the expense you are submitting; or
- The total amount that has been contributed to your dependent care account to date, reduced by previous claims paid from the account.

If there is not enough money in your dependent care account to pay all the expenses you have submitted during a payment period, the excess expenses will be carried forward; this is referred to as an 'on-hold' balance. You do not have to resubmit these suspended expenses for reimbursement as they will be paid from the deposits you make in subsequent periods. For income tax purposes, the statement you receive each time you get a reimbursement check will show the amount you actually received from your dependent care account for expenses incurred during the year.

Qualifying Status Changes

The plan provides that a change in your election may be allowed mid-plan year under certain circumstances in which the family's status has been affected. All changes must be reported to Risk Management within 30 days of the event. All changes must be consistent with the event as required by the IRS. The following events would allow a mid-year change to your Dependent care election:

- Change in number of employee's dependents (birth/adoption/death)
- Change in employment status of employee or employee spouse. Includes strike, lockout, termination of employment, or gaining employment.
- Change in Cost or Coverage.

The above examples are not comprehensive. If you have a question regarding status changes, please contact Risk Management at (651) 266-6500.

Leave of Absence

If you take a leave of absence and continue to receive regular pay, sick pay, or vacation pay from the City, your contribution to the dependent care account will continue to be deducted. If, during the leave of absence, you do not receive pay from the City, your participation under the plan will be treated the same as a termination of employment. Therefore, your contributions under the dependent care account will cease, but you can continue to submit claims through the end of the plan year or until your account is depleted, whichever is earlier.

When you return to work after the leave, your dependent care contributions will resume at the same level. You cannot make a new contribution election upon your return to work unless you incurred a change in family status.

Termination of Employment

If you terminate employment while participating in the dependent care account, you may continue to submit reimbursement requests for eligible expenses you incurred after termination for the remainder of the year. However, no new contributions may be made to the account. Any amounts remaining in the account after **February 16th will be forfeited.**

Tax Considerations

Under current law, a tax credit is available for the same type of dependent care expenses that are eligible for reimbursement through the plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a specified limit. For plan years beginning on or after January 1, 2007, the limit is $3,000 of expenses if there is one eligible dependent and $6,000 of expenses if there are two or more single dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the plan, and the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent care reimbursements you receive under the Plan.

For example, if you have two children for whom you incur $7,000 of dependent care expenses in 2009 and you have $2,000 reimbursed through the plan; the maximum amount of your expenses eligible for the tax credit is $4,000. The $2,000 reimbursed from the Plan cannot be considered for the tax credit, reducing the $6,000 (the maximum amount for two or more eligible dependents) to $4,000 ($6,000 less $2,000). This means that even though you incurred $7,000 of dependent care expenses, the total amount subject to a tax benefit is $6,000, $2,000 through the plan and $4,000 through the tax credit. Determining whether taking the credit or reimbursement under the plan is more beneficial involves complex calculations. Because each individual's situation is different, the City cannot predict whether or not it would be more beneficial to you to take the tax credit for dependent care expenses or have your expenses reimbursed under the plan.

Dependent Care Account or Tax Credit – Which is Right For You?

Both the dependent care account and the federal dependent care tax credit are designed to save you money on your dependent care expenses by reducing your taxes. But which is the best option to choose?

There is the perception that tax changes as a result of the Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001 have lessened the benefits of the dependent care account. However, because EGTRRA allows salary reductions for contributions to a dependent care account to increase an individual's earned income tax credits, more people will now benefit from participating in the dependent care account. EGTRRA has not yet reduced the tax-effectiveness of dependent care accounts.

Earned income is your family income from working (yours and your spouse's, if married) minus any pre-tax deductions for benefits. Generally, this is the income shown on your W-2.

Several issues help determine eligibility for earned income credit. Typically, the main issue for eligibility is if your earned income is low enough to qualify.

Pre-tax contributions you make for health care coverage, employee savings plans, and flexible spending accounts help reduce your earned income. Making these pre-tax contributions may help you qualify for the earned income tax credit. You may want to consult your tax advisor for further assistance, especially for factoring in any impact on state income taxes.

TRANSPORTATION ACCOUNT

Qualifying Expenses

This transportation plan will allow you to pay for your eligible parking expenses on a pre-tax basis, thereby reducing your taxable income.

This plan is regulated under Internal Revenue Code Section 132(f). The Code sets monthly maximums for reimbursement. Parking expenses cannot exceed $220 each month.

To participate in the Plan, you will make a monthly election when you become benefits eligible or during the Open Enrollment period.

Reimbursement for Transportation Expenses

When you incur an eligible transportation expense and submit the claim to the plan's administrator, Outsource*One*, the expense will be reimbursed from your account on a regular basis. The plan will pay the lesser of:

- The amount of the expense you are submitting; or
- The total amount that has been contributed to your transportation account to date, reduced by previous claims paid from the account. Not to exceed maximum monthly election.

If there is not enough money in your transportation account to pay all the expenses you have submitted during a pay period, the excess expenses will be carried forward (to the end of the month), this is referred to as an 'on-hold' balance. You do not have to resubmit these suspended expenses for reimbursement as they will be paid from the deposits you make in subsequent periods, not to exceed the monthly maximum allowed (the lesser of the amount contributed in a month or $220). For income tax purposes, the statement you receive each time you get a reimbursement check will show the amount you actually received from your transportation account for expenses incurred during the year.

A reimbursement claim form must be completed and signed, accompanied with the original or photocopy of the qualified transportation expense (i.e., parking invoice, parking receipt, etc.). A claim form may be printed from the Knowledge Base on the Benefit*Ready* system or the City's Intranet site: select Human Resources, Forms, Transportation Reimbursement Claim Form. In the event that a receipt or invoice is not available due to metered parking, unattended contract parking, or automated charge to a credit card, ***Self Certification*** may be accepted. Self Certification simply requires the participant to complete and sign the necessary reimbursement request form.

Note that the final deadline date for your transportation account is <u>NOT</u> the same as the final deadline date for your healthcare or dependent care account.

Termination of Employment

If you terminate employment while participating in the transportation account, you may continue to submit reimbursement requests for eligible expenses but only for claims incurred before you stopped working. Any amounts elected but not used, including amounts carried over from prior months, and remaining in the account **after January 30th will be forfeited**.

You may still have some questions about the plan. Hopefully they have been answered below:

Q. Who is eligible to participate in the plan?

A. Eligible employees include all benefit eligible employees of the City of Saint Paul working in a DOWNTOWN location. Employees of the Griffin Building are not eligible to participate in the parking plan.

Q. When may I begin to participate in the plan?

A. You may begin participation in the plan thirty (30) days after your date of hire and upon enrollment on the Benefit*Ready* system. Employees enrolling during the annual enrollment will begin participation January 1 of the new plan year. Monthly enrollments are also allowed.

Q. When may I begin submitting expenses for reimbursement?

A. You may begin submitting requests for reimbursement of expenses incurred after the date you become eligible for **and** enroll in the plan. Payments will be made on a regular basis. Claims are paid based on actual contribution. You may choose to receive a check in the mail or you may want to sign up for automatic direct deposit to your checking or savings account.

Q. Can I submit expenses that exceed the maximum allowable per month?

A. Yes. However, you will only be reimbursed the amount you elected or the maximum monthly allowance whichever is lower. For example, if you pay $225 for parking expenses in one month, you will be reimbursed for up to $220 (if elected). The additional $5 cannot be reimbursed the following month.

Q. What if my expenses are less than the amount I have elected?

A. Amounts elected but not used will be carried forward and may be used for qualified transportation expenses in future months. For example, if you elected $120/month because that is your typical monthly cost for parking, but this month you only incur $100 in parking expenses because you were on vacation, you would be reimbursed the $100, and the $20 balance would be carried forward. **Note that regardless of the amount rolled forward, the monthly reimbursement maximum cannot exceed $220 for parking.**

Q. Would my claim ever be denied for payment? Why?

A. Yes. If your Transportation Reimbursement Claim Form has information missing it will be denied. You must **sign** the claim form, without your signature the form will be denied. Submit an original or photocopy invoice (copies will only be accepted if the receipt has a full date listed, i.e. July 15, 2009), or receipt with your claim form. If a receipt for your transportation expense is not provided in the ordinary course of business, the claim may be submitted without a receipt, thereby self-certifying.

Q. What is "Self Certification" of transportation services?

A. In the event that a receipt or invoice is not available to substantiate requested expenses, the regulation provides a participant with the ability to "self certify" their expenses. Self Certification simply requires that the participant sign the claim form when a receipt or invoice is not available, such as metered parking. Be advised that by "self certifying" your claim you are legally certifying this expense to the IRS.

Q. Once I have made an election may I change it?

A. Elections can be changed monthly by contacting Risk Management. Initial and annual enrollment must be done on the Benefit*Ready* system.

Q. May I terminate participation in the plan?

A. Yes, on a monthly basis. Contact Risk Management at (651) 266-6500. Only amounts deducted and expenses incurred on or before your termination date will be eligible for reimbursement, however. When you terminate participation in the plan, any funds left in your account (either unused or unclaimed) after the plan close date of January 30th will be forfeited.

Q. Can I retain all of my receipts throughout the year and submit them all at the end of the year?

A. Yes. However, the plan was designed to benefit participants with the tax savings throughout the year. A recommendation would be to submit expenses throughout the year as you incur them. By waiting until the end of the year you also risk losing your receipts. REMEMBER: No more than the monthly maximum may be reimbursed for any given month.

Q. Is there a final deadline to submit prior year's claims?

A. You have until **January 30 4:30 PM CST** of the next year to submit prior year claims. After January 30, any unused or unclaimed contributions shall be carried over into the following plan year providing you elected to continue participation. For example, on December 31, 2008, you have $200 left in your transportation account. You submit your December parking claim on January 30, 2009 for $100.00. On February 1, $100.00 from your 2008 transportation account will be added to your 2009 transportation account to be used for expenses incurred in 2009. If you did not elect to participate for the following plan year unused or unclaimed funds will be forfeited. **Note that the final deadline date for your transportation account is NOT the same as the final deadline date for your healthcare or dependent care account.**

Q. Does it cost me anything to participate?

A. No. You can only save dollars by participating in this plan as long as you remain an employee.

Q. Can I submit expenses after I have terminated employment?

A. Yes, but only for claims incurred before you stopped working and those claims must be submitted by **January 30 4:30 PM CST** of the next plan year. Any amounts elected but not used, including amounts carried over from prior months, must be forfeited so plan carefully.

Q. Can I also claim transportation expenses my spouse incurs?

A. No, only expenses incurred by the participant (employee) are eligible for reimbursement.

Q. I carpool to work with someone. We park in a parking ramp contracted monthly. Can we each get reimbursed for half the cost of the parking spot?

A. No. The only person eligible to receive pre-tax reimbursement for the cost of the contracted parking spot is the prime member of the parking contract.

Q. May the City of Saint Paul amend or terminate the plan?

A. The City of Saint Paul has the right at any time and from time to time, by resolution of Risk Management, or such other persons to whom such authority has been delegated, to amend the Plan. The City of Saint Paul expects the Plan to be permanent, but necessarily must, and hereby does, reserve the right to terminate the Plan at any time.

Q. How do I receive reimbursement for these expenses?

A. A Reimbursement check and/or an Advice of Deposit will be sent to your home address. Be sure to keep your payroll personnel informed of any address changes. With each check you will receive an account summary that will list the reimbursement expenses paid and any deferred (suspended) amounts.

Q. How do I file a claim?

A. You must complete a reimbursement claim form. Claim forms are available to be printed from the Knowledge Base on the Benefit*Ready* system or from the City's Intranet HR site. Make sure to include all information requested on the form, sign it, and submit the claim form along with documentation to substantiate the expense to Outsource*One*.

Mail or fax your completed claim form to the plan administrator, Outsource*One*. Outsource*One* will then send tax-free reimbursement checks for eligible expenses to participants on a regular basis or directly deposit them in your bank account. See pages 48 through 50 for more information.

Outsource*One*
Attn: Transit Administration Dept.
730 2nd Avenue South, Suite 530
Minneapolis, MN 55402
Fax: (612) 335-9217
or (877) 491-6016

Q. I don't understand, how I will save taxes on these expenses?

A. Here is an *example*. Please note that your savings may differ, based on the assumptions made in this example.

Parking Expenses $195

	Without	With
Gross Income	$ 1,000	$ 1,000
Eligible receipts	$ 0	$ – 195
Adjusted Gross	$ 1,000	$ 805
Assumed Tax Rate 30%	$ – 300	$ – 242
Net Income	$ 700	$ 563
Eligible receipts	$ 0	$ + 195
Adjusted Net	$ **700**	$ **758**

This is an example only. Your actual tax savings will depend on your own individual circumstances. Also, tax benefits are not guaranteed by the Employer.

2008 RUN-OUT SCHEDULE

Plan Year 1/1/2008 through 12/31/2008

	Reimbursement Request Deadline by Close of Business (4:30 PM CST) on:
TRANSPORTATION FINAL →	**01/30/2009**
HEALTH & DEPENDENT CARE FINAL→	**02/16/2009**

All reimbursement requests for expenses for health care and dependent care (daycare) accounts incurred through December 31, 2008 must be documented and **received** at Outsource*One* by February 16, 2009. **Any funds remaining in your account(s) after February 16 following the end of the plan year will be forfeited**.

Final Submission deadline for transportation accounts is January 30, 2009.

ADDITIONAL INFORMATION

*Outsource*One *Reimbursement Procedures*

To obtain an Outsource*One* claim form, go to the Knowledge Base on the Benefit*Ready*, or go to the City Intranet website, select Human Resources, Forms, Medical and Dependent Care Reimbursement Claim Form or Transportation Reimbursement Claim Form. Health care expenses, dependent care, and transportation expenses will be reimbursed to you on a regular basis.

Remember, expenses incurred during one plan year cannot be reimbursed with money contributed in a prior or subsequent plan year, nor can amounts deposited in one account be used to reimburse expenses from another account. In addition, reimbursements under a Flexible Spending Account are based on service provided not service paid, therefore simply providing proof of payment for services rendered or expected service does not meet the IRS reimbursement requirements.

To be reimbursed for eligible health care, dependent care, or transportation expenses, you must complete a reimbursement claim form, detailing your expenses and include itemized receipts documenting the expense. Acceptable documentation would include an itemized receipt, an insurance company explanation of benefits (EOB), or an itemized statement of services provided (not paid) from the provider. The following items **must** be present on your supporting documentation:

1. Description of Service
2. Date of Service Provided (not paid)
3. Providers Name (and Tax ID for Dependent Care)
4. Amount of Participant Responsibility

In the event that itemized documentation is not available you may ask your provider to complete and sign the appropriate box on the Reimbursement Claim Form. Please keep a copy of the reimbursement claim form and documentation for your files.

Completed reimbursement claim forms and supporting documentation can be submitted via fax or mail to:

Outsource*One*
730 2nd Avenue South, Suite 530
Minneapolis, MN 55402
Fax: (612) 335-9217
Toll Free Fax: 1-877-491-6016

If you need additional forms or have any questions, contact Outsource*One* at (877) 491-5979.

Reimbursement Duplication

Duplication of reimbursements, attempts to take tax credits or deductions for reimbursed expenses, and/or filing erroneous claims constitute tax fraud, and you personally will incur any penalties. The City of Saint Paul does not have the means to monitor your personal income tax and other financial affairs, and will not attempt to do so. You should maintain adequate records to support your claims in the event of an inquiry by the IRS, and keep copies of all documentation sent to Outsource*One*.

Direct Deposit

You can also sign up to have your reimbursements direct deposited into your checking or savings account. Go to the Benefit*Ready* Knowledge Base or to the City's Intranet site to print a Direct Deposit Form. Complete this form and fax or send to Outsource*One* at the address and/or fax number below. You would still file your claims by sending in claim forms and documentation before the bi-weekly reimbursement request deadlines, but instead of Outsource*One* mailing your check, the funds would be transferred directly into your bank account on the distribution date. Please be aware that a pre-note is required, therefore your first reimbursement request might be mailed, and all subsequent reimbursements will be direct deposit.

Assistance Available

Outsource*One*'s Customer Service Department is ready to help! Calls are answered every business day from 8:00 a.m. to 5:00 p.m. Representatives can help you if you have specific questions about the health care account, dependent care account, and/or transportation account provisions. Their address and phone number is:

Outsource*One*
730 2nd Avenue South, Suite 530
Minneapolis MN 55402
Toll Free Fax: 877-491-6016
Phone: (612) 436-2778 or (877) 491-5979

Optional Insurance

DENTAL INSURANCE

HealthPartners dental Distinctions plan provides benefits for fillings, periodontics, endodontics, oral surgery, crowns, onlays, prosthetics, and orthodontics.

Eligibility

The dental Distinctions plan is available to employees who are eligible for insurance. However, you do not need to be enrolled in the health insurance plan to elect the optional dental coverage. Once you enroll, premiums will be deducted from your paycheck monthly, and you may not cancel coverage during the calendar year unless you experience a status change event, as defined on page 32. If you choose to discontinue your coverage, you will have a 24-month waiting period.

The 2009 premiums for dental insurance are unchanged from 2008.

Monthly Cost:

Employee	$21.53
Employee + 1	$43.01
Family	$78.22

Dental premiums will be deducted on a pre-tax basis, further reducing your cost.

Remember, you can save additional money by using a medical flexible spending account to pay for expenses not covered by the dental plan.

Networks

The dental Distinctions plan groups dentists and specialists into benefit Levels based on cost and quality criteria. Choose a dentist or specialist from Benefit level I to get the best quality at the best price, and you'll enjoy the lowest out-of-pocket costs. Or choose a dentist from Benefit Level II and pay a higher cost. The choice is yours. You never need a referral to see a specialist. Your Distinctions dental plan network includes more than 1,600 providers across Minnesota, western Wisconsin, Eastern North Dakota, and South Dakota. You can also choose to see a provider who's not in the network and pay the higher out-of-pocket costs.

Each family member may select a different clinic and benefit level and all members may change their selection anytime. There is no need to call to make a clinic change. With the optional dental plan, you can choose a different dental clinic than the one you chose under your medical plan for preventive services.

PLAN BENEFITS

DENTAL SERVICES	BENEFIT LEVEL I PROVIDERS	BENEFIT LEVEL II PROVIDERS	ANY LICENSED DENTIST
Annual Maximum (eligible benefit per person per year)	$1,250	$750 Combined across tiers	$500
Preventive/Diagnostic Care	100%	100%	100%
Sealants	100%	100%	100%
Annual Deductible (does not apply to preventive care)	$25 per person $75 per family	$50 per person $150 per family	$50 per person $150 per family
Basic I Services			
♦ Amalgam Fillings	100%	80%	80%
♦ Posterior Composites	80%	50%	50%
♦ Non-Surgical Periodontics	60%	50%	50%
♦ Endodontics (Root canal therapy)	60%	50%	50%
♦ Simple Extractions	60%	50%	50%
Basic II Services			
♦ Surgical periodontics	60%	50%	50%
♦ Complex Oral Surgery	60%	50%	50%
♦ Crowns, onlays	50%	50%	No Coverage
Prosthetics			
♦ Bridges, dentures & partial dentures	50%	50%	No Coverage
♦ Dental Implants	50%	50%	No Coverage
Orthodontics (no deductible)			
♦ For dependents to age 19	50%	50%	
♦ Lifetime maximum	$750	$500	No Coverage
♦ Does not apply to annual maximum (separate benefit)			

HealthPartners Orthodontic Discount

With the average orthodontic bill approaching $5,000, our 20% discount provides you with a significant savings opportunity. Here's how it works:

- ♦ This discount is available to HealthPartners dental members of all ages whether or not you have orthodontic coverage or not!
- ♦ You will receive a 20% discount on all care.
- ♦ Members will receive discounted services at any of the Orthodontic Care Specialists' 19 metro locations.
- ♦ Simply present your HealthPartners Dental ID card at your first visit to obtain your discount.

To learn more, check out our web sit at www.healthpartners.com or visit www.orthodonticare.com for location details.

Enrollment

To enroll in the HealthPartners dental Distinctions plan, go online in Benefit*Ready* and elect employee, employee +1 or family coverage.

Identification Cards/Plan Information

If you are enrolling in HealthPartners dental Distinctions plan for the first time, you will receive an identification (ID) card for each covered family member along with a Group Membership Contract and Member Handbook. Continuing members will receive a Group Membership Contract and Appendix. You will receive these materials by January 1, 2009.

Provider Information and Directories

HealthPartners Dental Network CD-ROM directories will be available at all open enrollment information sessions. You can also receive a Dental Network directory by calling HealthPartners Member Services at (952) 883-5000 or (800) 883-2177, as well as at the HealthPartners web site. Find a provider by clicking on "**Compare & Select Providers**," then "**Find Doctors, Clinics, Hospitals, and Other Providers**." Select "**HealthPartners Dental Distinctions"** in the dental plans section.

Dental Plan enhancements for 2009

Diabetes and Maternity Care

More and more research points to a connection between good oral and overall health, especially for those who are diabetic or pregnant. That's why HealthPartners now offers enhanced coverage above and beyond standard plan benefits, such as additional exams, cleanings and other necessary periodontal services, to pregnant and diabetic members.

Kids 12 and Under are Free

A lifetime of good oral health starts when you're young. That's why HealthPartners is offering something new – and unique to dental plans – this year. HealthPartners now covers all services included in your dental plan that are performed by network providers for children 12 and under at 100 percent, with no deductibles or coinsurances.

Dental Implants

In some instances dental implants are the best option. In addition to HealthPartners current coverage of prosthetics for implants, HealthPartners is expanding the benefit to include the surgical portion of the treatment too.

Q. Do I have to be enrolled in the health insurance plan to opt for the voluntary dental plan?

A. No, you do not need to be enrolled in the health insurance plan; you only need to meet the eligibility requirements listed on page 51.

Q. Is preventive dental still covered under my health insurance plan?

A. Yes. However, the two cleanings under each plan will be coordinated. You will not be eligible for four cleanings and exams per year, and preventive charges do not apply toward your dental annual maximum.

Q. Does my dental clinic need to be the same for my health insurance plan as for my optional dental plan?

A. No, you may choose a different dental clinic under each plan.

Q. Is there an out-of-network option?

A. Yes.

Q. Is the annual maximum per family or per member?

A. Each family member has an annual maximum benefit of $1,250 or $500, depending upon Benefit Level I, Level II, or any licensed dentist.

Q. Are all charges, including preventive and diagnostic, applied toward the annual maximum?

A. Yes. Any benefits HealthPartners pays for your dental care and treatment will be applied toward your annual maximum benefit. Note: if you carry HealthPartners health insurance, your preventive/diagnostic charges will be covered under that plan, leaving your annual maximum intact for regular and special restorative care.

Q. Is dental insurance subject to enrollment each year?

A. Yes. You can choose to enroll or cancel participation for the following year during open enrollment. However, enrollees who cancel must wait 24 months before re-enrolling.

Q. Does HealthPartners cover "Work in Progress"?

A. There are certain circumstances where HealthPartners would not cover **work in progress**. For example:

Crowns: If a tooth has been prepared and impressions have been taken before the member was covered under a HealthPartners dental contract, the crown will not be covered.

Root Canal Treatment: If root canal treatment was initiated (pulp chamber has been opened) before the member was covered under a HealthPartners dental contract, the root canal is not covered.

Prosthetics: Treatment including fixed and removable prosthetics, which began or were ordered before a member was covered under a HealthPartners dental contract, is not covered. In the case of dentures, ordered means that impressions have been taken from which the denture will be prepared. In the case of fixed prosthetics (bridgework), the teeth that serve as abutments or support have been prepared and impressions have been taken.

Orthodontics: Members whose orthodontic treatment is in progress (bands are still in place) should have their treating dentist submit a claim form with the following information: total treatment cost, total length of treatment, down payment, and payments made by previous carrier.

LIFE INSURANCE

Employer Group Life Insurance

Term life insurance and accidental death or dismemberment insurance is provided by the City of Saint Paul for most of its employees. All employees of the City of Saint Paul who have met the eligibility requirements for the City-sponsored health insurance plan are eligible for employer group life insurance. Your **Benefit*Ready* Account** indicates your amount of coverage as specified in your collective bargaining unit agreement or City Council Resolution.

Optional Life Insurance

The City's optional term life insurance program has been designed exclusively for City of Saint Paul employees. By updating your life insurance, you can make sure your loved ones would be financially secure if you were to die. Your **Benefit*Ready* Account** indicates the current amount of life insurance coverage you chose for yourself, your spouse, or your dependents, in addition to the employer-paid insurance.

The following information is intended as a general guide to the term life insurance plan. Full details of the insurance program are provided in the Certificate of Insurance available on the City website. You can contact a Hays Companies representative at (612) 347-8410 for more information. Hays Companies representatives will also be available to assist you during the open enrollment information sessions.

Insurance Coverage Available

You can apply for up to $300,000 of additional life insurance in units of $5,000. Your plan covers death from any cause except suicide in the first two years after you enroll in the plan.

New employees who enroll in this plan within 45 days of their date of hire may elect an insurance amount equal to two times their annual salary or the amount shown below, whichever is less. The amounts of insurance will be issued on a guaranteed approval basis.

New Employees

Age at Employment	Guaranteed Issue Amounts
Under 35	$100,000
35-39	$ 50,000
40-44	$ 35,000
45-59	$ 25,000
60 and over	$ 0

Generally, you will have to provide evidence of insurability and complete a health questionnaire after this initial enrollment period, and coverage will take effect following approval of the application by the insurance company. To apply for increased coverage during the annual enrollment, you will need to print out and complete the health questionnaire available in your **Benefit*Ready* Account** or call Hays Companies at (612) 347-8410 to have the form sent to you.

Insurance for Spouse

This plan offers the opportunity to insure your spouse in the same amounts and increments which are available to employees. It is not necessary to purchase employee life to be eligible for additional spouse life coverage. If you are applying for coverage as both an employee and a spouse, the total amount of coverage on such individual cannot exceed $300,000. With insurance covering both heads of your household, you can be more certain of a secure future for your family. New employees are eligible for $10,000 of spouse coverage on a guaranteed approval basis. During annual enrollment, you must complete the health questionnaire available in your **Benefit*Ready* Account** to increase coverage.

Insurance for Children

This plan also allows you to obtain life insurance coverage for your children. For only $1.30 a month, *all* of your eligible children can be insured. Children from 14 days to six-months-old will receive $1,000 in life insurance coverage, while children from six months to 21 years (25 years for full-time students) will receive $10,000 in coverage. New employees may choose this coverage on a guaranteed approval basis. During annual enrollment, the health questionnaire available in your **Benefit*Ready* Account** is required.

Accidental Death Benefits

Employees and spouses who enroll in the optional life insurance plan are both eligible for double benefits if either dies as a result of an accident. This means that, if you had $50,000 of life insurance, and then died due to an accident, $100,000 would be paid to the person you selected as your beneficiary.

Dismemberment Benefits

This insurance plan also pays benefits if you or your insured spouse should suffer loss of limb or eyesight. The plan exclusions existing for both dismemberment and accidental death are fully detailed in the plan certificate.

Monthly Benefit and Cost

The employee and spouse's life premium is based on age. (See Table below for Optional Life Insurance Premiums). Rates are determined by your attained age on January 1.

Your Age or Age of Your Spouse	Your Monthly Cost per $1,000
Under 30	$ .08
30-39	$ .09
40-44	$ .11
45-49	$ .15
50-54	$ .23
55-59	$ .38
60-64	$ .57
65-69	$1.06
70+	$1.71

Beneficiary

If you do not name a beneficiary, or if there is no named beneficiary surviving at the time of your death, the amount of your insurance will be paid according to the following order of priority: 1) Your surviving lawful wife or husband; 2) Your surviving children in equal shares; 3) Your surviving parents in equal shares; 4) The duly appointed legal representative of your estate. "Children" means only first generation lawful bodily issue and legally adopted persons. Beneficiary designation is completed online in your **Benefit*Ready* Account.**

Continuation and Conversion

If you leave City employment or retire, you can continue to purchase term insurance for 18 months through the City's plan. After 18 months, you can continue to purchase additional insurance by changing to one of the individual policies provided by the insurance underwriters. No health questions will be asked when you convert your insurance, as long as you contact Hays Companies at (612) 347-8410 to apply within 31 days after the 18 month continuation period. Individual policy premiums will be based on you and/or your spouse's age at application.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's life insurance program is available on the Saint Paul web site at:

http://www.stpaul.gov/benefits

SHORT TERM DISABILITY INSURANCE

Short term disability insurance is available to eligible City of Saint Paul employees through Assurant Employee Benefits. Short term disability is just what its name implies; an insurance program that pays you a monthly income while you recover from a short term (less than six months) injury or illness. The short term disability insurance program allows you to receive your monthly short term disability benefit plus any sick leave or compensated leave you choose to take, as long as you don't receive more than 100% of your normal salary (the minimum benefit you will receive from short term disability is $25 per week, even if it exceeds the 100% of weekly pay).

The following information is intended as a general guide to the short term disability program. Full details are provided in the Certificate of Insurance. You can contact a Hays Companies representative at (612) 347-8410 for more information. Hays Companies representatives will also be available to assist you during the open enrollment information sessions.

Insurance Coverage Available

Under the City of Saint Paul's plan, you can apply for a monthly benefit of up to $2,000, provided it doesn't exceed 66-2/3% of your gross monthly salary. You could be paid up to a maximum of 26 weeks for short term disability, depending on your physician's verification of disability. These are cash payments made to you to help compensate for the loss of wages following your injury or illness. This is insurance coverage for an injury or illness you may sustain while *not* on the job. No benefits are paid if you are eligible for workers compensation. You begin to receive the benefits on the first day of an accident, or on the eighth calendar day of an illness which prevents you from working. Your first check will arrive about 30 days after the onset of illness or injury.

New employees who enroll in this plan within 45 days of their date of hire may elect up to their maximum benefit on an automatic approval basis. During open enrollment (October 1 to October 17, 2008), employees currently enrolled in short term disability insurance may increase by $100 in monthly benefits without completion of a health questionnaire. Employees can also increase to a higher monthly benefit subject to approval of a health questionnaire, as can those not currently covered, provided that they do not exceed the maximum for their salary. The health questionnaire can be obtained in your **Benefit*Ready* Account** or by calling at Hays Companies at (612) 347-8410.

Monthly Benefit and Cost

Premium payments for short term disability insurance are automatically deducted from your paychecks. As shown in the table, the cost of short term disability insurance is $1.83 per month per $100 monthly benefit.

The cost of your short term disability coverage depends on the monthly benefit amount you select. You may choose any benefit amount shown in the chart below up to the maximum monthly benefit amount that corresponds with your monthly salary.

Employee's Monthly Salary	Maximum Monthly Benefit	Monthly Premium
$ 300	$ 200	$ 3.66
$ 450	$ 300	$ 5.49
$ 600	$ 400	$ 7.32
$ 750	$ 500	$ 9.15
$ 900	$ 600	$10.98
$1,050	$ 700	$12.81
$1,200	$ 800	$14.64
$1,350	$ 900	$16.47
$1,500	$1,000	$18.30
$1,650	$1,100	$20.13
$1,800	$1,200	$21.96
$1,950	$1,300	$23.79
$2,100	$1,400	$25.62
$2,250	$1,500	$27.45
$2,400	$1,600	$29.28
$2,550	$1,700	$31.11
$2,700	$1,800	$32.94
$2,850	$1,900	$34.77
$3,000+	$2,000	$36.60

Definition of Disability

- **Occupation Test:** You are considered disabled if due to an injury, sickness, or pregnancy, you are unable to perform one of the material duties of your regular occupation.
- **Earnings Test:** If you are working and are not disabled by the occupation test, you will still be considered disabled if an injury, sickness, or pregnancy prevents you from earning more than 80% of pre-disability pay.

Determination of disability is made by the insurance company. The information above is just a general definition.

Minimum/Maximum Benefit

When combined with your short term disability benefit, you may also receive sick pay or partial disability earnings provided you don't exceed 100% of your regular weekly pay (please note the minimum benefit you will receive from short term disability is $25 per week, even if it exceeds the 100% of weekly pay). The excess, if any, will be subtracted directly from your short term disability benefit.

Restrictions

The plan doesn't cover injury or sickness resulting from commission of a felony or if benefits are payable under any workers' compensation, employers liability occupational disease law, or similar law or act.

Continuation and Conversion

If you leave employment or retire, you *cannot* continue to purchase this coverage or continue to participate in the City's short term disability program.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's short term disability insurance program is available on the Saint Paul web site at:

http://www.stpaul.gov/benefits

LONG TERM DISABILITY INSURANCE

The long term disability insurance program is offered to eligible City employees through Assurant Employee Benefits. Long term disability means you can receive a monthly income while recovering from a long term (over six months) illness or injury that prevents you from working. Long term disability insurance is a practical and cost-effective way to assure that you have continued income if you become disabled and can no longer work. The following is intended as a general guide to the long term disability program. Full details of the insurance program are provided in the Certificate of Insurance. You can contact a Hays Companies representative at (612) 347-8410 for more information, and representatives will be available to assist you during open enrollment information sessions.

Insurance Coverage Available

You can receive a monthly benefit check based on your annual salary. You can receive as little as $500 a month to as much as $5,000 a month from the long term disability benefits provided you do not exceed 60 % of your salary. Payment of benefits starts on the latter of six months of continuous disability, the end of short term disability benefits, or the end of all sick leave, donated sick leave, vacation pay, or other salary continuance. Remember that short term disability benefits can cover you up to 26 weeks. The length of the benefit payment is shown below:

Age at Disability	Length of Payment
Prior to age 60	To the day before retirement age*
After age 60 but before age 65	The longer of 36 months or the day before retirement age*
After age 65 but before age 68	24 months
After age 68 but before age 70	18 months
After age 70 but before age 72	15 months
Age 72 or more	12 months

* **Retirement Age** means the Social Security Normal Retirement Age

New employees who enroll in this plan within 45 days of their date of hire may elect up to their maximum benefit on an automatic approval basis. Coverage is subject to the pre-existing condition restriction. During open enrollment (October 1 to October 17, 2008), employees who currently participate in the plan can increase their monthly benefit up to the maximum for their salary by making a new election in your **Benefit*Ready* Account**. New amounts are subject to the pre-existing condition restriction. Employees who are not currently enrolled may apply, subject to approval of a health questionnaire available in your **Benefit*Ready* Account** or by calling Hays Companies at (612) 347-8410.

Monthly Benefit

The cost of your LTD protection is determined by the amount of coverage you choose. To determine the maximum amount for which you are eligible, locate your monthly salary in the first column, and cross over to the next column, Maximum Monthly Benefit Amount. You may enroll for any amount of coverage as shown up to that maximum amount. Before you enroll, make sure you understand how benefits are calculated.

Your Gross Monthly Salary	Maximum Monthly Benefit Amount
Minimum $1,000	$ 500
$ 1,000	$ 600
$ 1,167	$ 700
$ 1,334	$ 800
$ 1,500	$ 900
$ 1,667	$ 1,000
$ 1,834	$ 1,100
$ 2,000	$ 1,200
$ 2,167	$ 1,300
$ 2,334	$ 1,400
$ 2,500	$ 1,500
$ 2,667	$ 1,600
$ 2,834	$ 1,700
$ 3,000	$ 1,800
$ 3,167	$ 1,900
$ 3,334	$ 2,000
$ 3,500	$ 2,100
$ 3,667	$ 2,200
$ 3,834	$ 2,300
$ 4,000	$ 2,400
$ 4,167	$ 2,500
$ 4,334	$ 2,600
$ 4,500	$ 2,700

Your Gross Monthly Salary	Maximum Monthly Benefit Amount
$ 4,667	$ 2,800
$ 4,834	$ 2,900
$ 5,000	$ 3,000
$ 5,167	$ 3,100
$ 5,333	$ 3,200
$ 5,500	$ 3,300
$ 5,667	$ 3,400
$ 5,834	$ 3,500
$ 6,000	$ 3,600
$ 6,167	$ 3,700
$ 6,334	$ 3,800
$ 6,500	$ 3,900
$ 6,667	$ 4,000
$ 6,834	$ 4,100
$ 7,000	$ 4,200
$ 7,167	$ 4,300
$ 7,334	$ 4,400
$ 7,500	$ 4,500
$ 7,667	$ 4,600
$ 7,834	$ 4,700
$ 8,000	$ 4,800
$ 8,167	$ 4,900
$ 8,334 and up	$ 5,000

Monthly Cost

Premium payments are automatically deducted from your paychecks. The following table shows what the monthly cost would be per $100 monthly benefit ($500 minimum required):

Age	Cost per Month per $100	Cost per Month per $500
00-24	$ .25	$ 1.25
25-29	$ .36	$ 1.80
30-34	$ .53	$ 2.65
35-39	$ .80	$ 4.00
40-44	$ 1.20	$ 6.00
45-49	$ 1.86	$ 9.30
50-54	$ 2.76	$ 13.80
55+	$ 3.00	$ 15.00

Use the following format to calculate your cost:

Example: Age 38 electing a $1,500 monthly benefit

$1,500 (Monthly benefit)	X	.80/$100 (Cost for age bracket)	=	$12.00 per month (Cost per month)

Integrated Benefits

You can receive long term disability benefits **in addition** to disability benefits received from other sources. The maximum benefit payable from **all** sources is 70% of salary. The payable benefit is coordinated with other disability income. If the sum of benefits received from other sources plus the long term disability monthly benefit exceeds 70% of the disabled person's monthly earnings, the long term disability benefit will be reduced by the excess. Other sources of income could include retirement or disability benefits from a retirement plan, workers compensation, social security, etc. Please note that the minimum benefit you will receive from long term disability insurance is $100 per month, even if you are receiving in excess of 70% of salary from other sources

Definition of Disability

- **Occupation Test:** You are considered disabled if, during the first 36 months of a period of disability, you are under the regular care of a licensed physician other than yourself and are unable to perform the material duties of your regular occupation or employment. After the first 36 months of a period of disability, you will continue to be considered disabled if you are unable to perform the material duties of any and every gainful occupation or employment for which you are, or become, reasonably fitted by education, training, or experience.
- **Earnings Test:** If you are working and are not disabled by the **occupation** test, you will still be considered disabled during any month you are not able, because of injury, sickness, or pregnancy, to earn more than 80% of your pre-disability monthly earnings.

Determination of disability is made by the insurance company. The information above is just a general definition.

Restrictions

Coverage for pre-existing conditions will begin 12 months following the effective date of coverage provided that you are actively at work at that time and have been insured under the plan for a full year without interruption. Pre-existing conditions are those for which you sought treatment during the three months prior to the effective date of coverage. In addition, you are not covered if the injury or illness resulted from war or any act of war, whether declared or not; intentionally self-inflicted injury, while sane or insane; or taking part in or the result of taking part in committing an assault or felony.

Managed Disability Solutions

While Assurant's disability plans provide financial support during a period of disability, resources are also devoted through their **Quality of Care Benefit** and **Managed Rehabilitation Benefit**, which combine to form Managed Disability Solutions. The goal is to help employees get back to work and regain a healthier, more productive lifestyle. The **Quality of Care Benefit** provides doctors and nurses who act to help disabled employees improve their health and return to work. **Managed Rehabilitation** captures the Assurant commitment to helping the City and its employees through vocational rehabilitation initiatives. When used in concert as Managed Disability Solutions, they provide a powerful approach to rehabilitation.

Continuation and Conversion

If you leave employment or retire, you can convert to your own long term disability plan. The benefits of the conversion policy will be those offered by the insurance company for conversion at the time you apply. To be eligible for conversion, you must have been insured under the long term disability plan for a year, apply within 31 days of termination, and pay the required premium. The availability of the conversion is dependent upon the reason for termination of coverage. Conversion plan provisions and costs may differ from the in-force policy. To apply for conversion, you can call Hays Companies at (612) 347-8410.

Survivor Benefit

If a disabled insured dies while receiving benefits, the disability benefit will continue to be paid for three months to the person's spouse. If the insured has no spouse, the benefit will be paid to children under age 21 and unmarried on the day the disabled insured dies. If there are no survivors, no benefit will be paid.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's long term disability insurance program is available on the Saint Paul web site at:

http://www.stpaul.gov/benefits

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Accidental death and dismemberment insurance is available to City of Saint Paul employees through Assurant Employee Benefits. Eligible employees are entitled to purchase this insurance to provide added benefits in the event of loss of life or limb. The accidental death and dismemberment policy provides for a lump sum payment in the event of the accidental loss of life, dismemberment, or loss of sight. In the event of an accidental death, your beneficiary will receive accidental death and dismemberment benefits **in addition** to any other life insurance benefits for which you qualify.

The following information is intended as a general guide to the accidental death and dismemberment insurance policy. Full details of the insurance program are provided in the Certificate of Insurance. You can contact a Hays Companies representative at (612) 347-8410 for more information. Hays Companies representatives will also be available to assist you during the open enrollment information sessions.

Insurance Coverage Available

Employees can purchase from $5,000 to $100,000 in accidental death and dismemberment benefits (in $5,000 increments). Employees under age 60 may apply for a maximum of $100,000, no health questions are asked. Employees age 60 or more may apply for up to a plan maximum of $50,000. Spouse coverage is limited to 50% of the coverage selected by the employee and a plan maximum of $50,000. You can enroll for coverage in your **Benefit*Ready* Account.**

Monthly Benefit and Cost

This insurance provides up to $100,000 coverage at very little cost. The cost per $1,000 of coverage is $.06 per month, which is the same as it was for 2008. Coverage is available in $5,000 units. Monthly premium payments are automatically deducted from your paychecks.

Beneficiary

If you do not name a beneficiary, or if there is no named beneficiary surviving at the time of your death, the amount of your insurance will be paid according to the following order of priority: 1) Your surviving lawful wife or husband; 2) Your surviving children in equal shares; 3) Your surviving parents in equal shares; 4) The duly appointed legal representative of your estate. "Children" means only first generation lawful bodily issue and legally adopted persons. Beneficiary designation is completed online in your **Benefit*Ready* Account.**

Continuation and Conversion

If you leave employment or retire, you *cannot* continue to purchase this coverage or continue to participate in the accidental death and dismemberment program.

Certificate of Insurance

Your Certificate of Insurance which provides in detail the provisions of the City's accidental death and dismemberment insurance program is available on the Saint Paul website at:

http://www.stpaul.gov/benefits

LONG TERM CARE INSURANCE

THE MUNICIPAL POOL

Plan Summary

*The following is an overview of the group long-term care insurance plan. Please call toll-free: (**888) 825-0686** or visit our website: www.ltcbenefits.com (password: munipool) for additional rates and plan information.*

Eligibility	All persons eligible for other employee benefits may enroll, as well as their spouses, retirees and their spouses, parents, parents-in-law, grandparents and grandparents-in-law. Spouses of employees, retirees and their spouses, parents, parents-in-law, grandparents and grandparents-in-law may enroll regardless of whether the employee enrolls and premiums are based on their age, not the employee's.
Underwriting	During the initial enrollment and at the time of hire, employees need only be actively at work on the effective date of coverage to qualify. No other questions will be asked. After the initial enrollment, employees must complete a short application form concerning medical history. At all times, spouses must complete a short application form and parents, parents-in-law, grandparents, and grandparents-in-law must complete a long form application.
Cost	Premiums are based on a person's age at the time the policy becomes effective. Enrollees can apply for a state tax credit of up to $100 per policy per year. Premium quotes are available up to age 90 upon request.
Payment	Employees and spouses will pay their premiums through payroll deduction. Retirees and their spouses, parents, parents-in-law, grandparents, and grandparents-in-law may pay their premiums through direct billing or automatic bank draft.
Portability	An employee may continue coverage if he/she retires or otherwise leaves employment. The coverage and rates remain the same.

Benefits	Plan A			Plan B		
Lifetime benefit maximum	$100,000	$150,000	$187,500	$146,000	$219,000	$273,750
Nursing home daily maximum	$80/day (3.4 years)	$120/day (3.4 years)	$150/day (3.4 years)	$80/day (5 years)	$120/day (5 years)	$150/day (5 years)
Assisted living daily maximum	$64/day (4.3 years)	$96/day (4.3 years)	$120/day (4.3 years)	$64/day (6.3 years)	$96/day (6.3 years)	$120/day (6.3 years)
Home health care, home hospice care, adult day care, and adult foster care monthly maximum	$1,800/mo (4.6 years)	$2,700/mo (4.6 years)	$3,375/mo (4.6 years)	$1,800/mo (6.8 years)	$2,700/mo (6.8 years)	$3,375/mo (6.8 years)
Return of premium	If an enrollee dies prior to age 65, 100% of premiums paid (minus benefits received) are returned to enrollee's estate. After age 65, the percentage decreases by 10% each year until age 75.					
Inflation protection	Opportunity to purchase additional coverage every 3 years so that value of coverage keeps pace with inflation.					

Other Options

In addition to the four options featured above, the following options are available upon request:

- An automatic benefit increase option enables your benefit to automatically keep pace with inflation. This benefit will automatically increase the amount of your daily nursing home and home health care benefits each year by 5% of the prior year's amount for life.
- A benefit account non-forfeiture option that guarantees some coverage if your policy lapses.

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ENROLLMENT AND CLAIM PROCEDURES

The City of Saint Paul's optional life insurance program is underwritten by the Minnesota Life Insurance Company. The short term disability insurance, long term disability insurance and accidental death and dismemberment insurance policies are offered through Assurant Employee Benefits. CNA is the insurance carrier for Long Term Care Insurance. Life insurance, short term disability, long term disability, and accidental death and dismemberment coverages are subject to enrollment and cancellation as a new employee and at open enrollment only. Mid-year changes are not allowed. Please consider your options carefully.

Enrollment

Enrollment is easy.

- If you are changing current optional coverage amounts, you need to show that change in your **Benefit*Ready* Account**. You can print the health questionnaire, if required, directly from your **Benefit*Ready* Account**.
- Remember that <u>all</u> insurance increases, <u>new enrollment</u> in short or long term disability, or short term disability increases <u>greater</u> than the $100/month "open" require the health questionnaire. You should check with a Hays Companies representative to determine if the coverages for which you are applying require this form.
- If you are currently enrolled in short term disability, you increase your monthly benefit by $100 directly in your **Benefit*Ready* Account**.
- If you are currently enrolled in the long term disability plan, you increase your monthly benefit directly in your **Benefit*Ready* Account**.
- You can elect or increase accidental death and dismemberment for you or your spouse directly in your **Benefit*Ready* Account**.
- You reduce or cancel you optional coverage directly in your **Benefit*Ready* Account**.

For long term care insurance, you need to complete a separate enrollment form. Packets will be available at the open enrollment information sessions.

Representatives from Hays Companies will be available at all of the open enrollment information sessions to assist you in completing your forms or answering questions. You can also contact Hays Companies by telephone at (612) 347-8410.

If you do not make changes to your OPTIONAL insurance coverages in your Benefit*Ready* Account by October 17, 2008, your current <u>optional</u> life, disability, and accidental death and dismemberment coverages will remain the same in 2009.

Claims

Risk Management, (651) 266-6500, can provide you with the proper forms you need to complete in order to claim any life or disability benefits.

CONTINUATION OF BENEFITS

Under federal and/or state regulations, you may continue your participation in the City's group health insurance plan, dental insurance, the health care account, and some life insurance coverages. The method and duration of continuing coverage are dependent upon the circumstances under which eligibility for coverage is lost (the "qualifying event"). Qualifying events:

- Dependent's loss of eligibility for dependent status
- Divorce or legal separation of employee
- Major/substantial reduction in hours worked of employee which results in a loss of benefits
- Unpaid leave of absence of employee
- Death of employee
- Employee's termination of employment for a reason other than gross misconduct

If the qualifying event is leave of absence, see pages 70 through 72. Otherwise, the federal and state COBRA laws require that the City offers continuation of coverage to the following qualified persons:

- An employee (and his/her covered dependents) whose coverage would otherwise end due to: (a) termination of employment for a reason other than gross misconduct; or, (b) a discontinuance of the employee's pay (i.e., layoff, suspension, or leave of absence); (c) loss of benefit eligibility (i.e., significant reduction of hours worked, or change in title or bargaining unit disallowing benefits);
- An employee's surviving spouse and/or children whose coverage would otherwise end due to the employee's death;
- An employee's spouse and/or children whose coverage would otherwise end due to divorce or legal separation;
- An employee's spouse and/or children whose coverage would otherwise end due to the employee's election to drop out of the health plan upon the employee's entitlement to Medicare; and,
- An employee's child whose coverage would otherwise end due to ceasing to be a dependent child under the generally applicable requirements.

Exception: Continuation is not available to any employee, spouse, ex-spouse, or dependent that becomes covered under any other group health plan, except as may otherwise be provided by law.

Notice Requirements

The employer is responsible to give qualified persons written notice of their continuation rights, obligations, and costs when a qualifying event occurs. If a qualified dependent ceases to be eligible for coverage due to divorce or the loss of dependent status, notice must be provided to the employer within 60 days of the event.

Election Requirements

Continued coverage is not automatic. The qualified person must elect to continue any or all of the eligible benefits in which s/he was enrolled. The period during which continuation coverage can be elected:

- Must begin no later than the date coverage would otherwise end due to a qualifying event; and,
- Must be within 60 days of the qualifying event date or such other period as required by state law; and,
- May not end earlier than 60 days, or such other period as required by state law, after the coverage ends, due to a qualifying event, and after the qualified beneficiary receives notice of his or her continuation rights.

Failure to return the election form within the stated 60 day period will result in termination of eligibility. Your initial contribution will include the cost of coverage, retroactive to the date of the qualifying event, and is payable at the time of election. If an election is made during the qualifying 60 day period after the qualifying event, the plan shall permit payment for continuation coverage 45 days after the date of the election. If full payment for the original contribution is not received within 45 days of the date of your election to continue coverage, your coverage will be terminated for non-payment, effective the end of the month in which the qualifying event took place.

Monthly Premium

A person who elects continuation will be required to pay the entire cost of the continued coverage plus a 2% COBRA administration charge when applicable. Failure to pay the monthly premium will result in cancellation of coverage.

Continuation Period

Continued coverage will end on the earliest of the following dates:

- For qualified persons described above (pertaining to termination of employment or discontinuance of pay or loss of benefit eligibility), the date coverage has been continued for 18 months; or, for all other qualified persons, the date coverage has been continued for 36 months or such other period as required by state law.
- With respect to each qualified person, the date that person becomes covered under any other group health plan as a result of employment or re-employment.
- The end of the period for which contribution is paid; if the required contribution is not paid on a timely basis (required payments are the responsibility of the qualified person).
- The date the City plan is terminated, if ever.

Leaves of Absence/Layoff/Suspension

If you take a voluntary leave under the Civil Service Rules, or experience a layoff or suspension, or take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993, the way in which you may participate in the plan will depend on whether or not you continue to receive compensation from the City. If, during a leave, you continue to be paid by the City, your benefit elections can remain in effect and the City will continue to pay its portion of your premiums and withhold your contributions. If you are not being paid by the City your participation in the plans will be treated in the same way as if you had terminated employment (see above). You may elect to continue to pay for your health insurance, some life insurance, and any health care expense reimbursement benefits on an after-tax basis. If you continue coverage, your prior benefit election will be reinstated when you return to work. If you

do not continue your benefits, they will not be reinstated upon your return to work. You will be canceled and your next opportunity to reinstate will be during open enrollment for the following year.

If you take a voluntary leave under the Civil Service Rules, or experience a layoff or suspension, or take a leave of absence that is a family or medical leave under the Family and Medical Leave Act of 1993, you should contact Risk Management to discuss your continued participation in the benefit plans during your absence. In general, if you take an unpaid family or medical leave, you may continue to participate in the benefit plans, provided you continue to pay your portion of premiums and contributions on an after-tax basis during the leave by sending your payment to Outsource*One* after you receive the monthly premium due notice from the City.

If you receive taxable pay from the City during your leave, you will continue to pay for your benefits on a pre-tax basis through contributions from that pay.

In addition, if you are on a family or medical leave under the Family and Medical Leave Act of 1993, at any point during the plan year, you will be entitled to revoke your election with respect to medical coverage and any medical expense reimbursement benefits under the plan. In addition, following your return from the family or medical leave, you will be entitled to reinstate those coverages for the remainder of the plan year, on the terms that applied prior to the leave. However, if you reinstate medical reimbursement coverage under the health care flexible spending account following a family or medical leave:

- Your period of coverage for the plan year will exclude periods for which your coverage had lapsed because of the revocation or termination;
- No expenses incurred during the excluded period will be eligible for reimbursement under the plan;
- Your level of coverage for the plan year of the reinstatement will equal your coverage level in effect at the time of your revocation or termination, reduced on a pro rata basis to reflect excluded periods for which your coverage had lapsed; and
- All previously paid benefits will be charged against your revised coverage level.

For example, assume that Stacey elected $1,200 of medical reimbursement coverage for the plan year and was paying for this benefit on a pre-tax basis. On April 1, Stacey began a family/medical leave that extended through May. Through March 31 reimbursable medical expenses in the amount of $400 were incurred. Stacey revoked his/her election on April 1 and reinstated the coverage on June 1. Because Stacey revoked the election rather than continuing it and paying for the coverage any medical expenses incurred from April 1 through May 31 would not be eligible for reimbursement. Upon reinstatement, the period of coverage for the plan year will be January through March and June through December, unless there is an earlier termination under the rules that apply to all participants. Because of this two-month lapse, upon reinstatement, Stacey's election for the plan year will be adjusted from $1,200 to $1,000. Because Stacey has already received $400 of benefits, Stacey will be eligible for up to $600 of additional reimbursement for the plan year.

Any revocation or request for reinstatement in the City's group health insurance must be made using the **group insurance application**. Any revocation or request for reinstatement in the health care account must be made using the **group insurance application**. In the case of a revocation, the application must be submitted no later than 30 days after the commencement of the family and medical leave. In the case of a request for reinstatement, the form must be submitted no later than 30 days after return from the family or medical leave. If the employee continues on unpaid leave after the expiration of either FMLA or Voluntary Leave, the expected duration of the leave will determine whether the City will continue to bill the employee for the full premium or whether Outsource One will be notified to offer COBRA election.

If you take a military leave of absence you may have a right to have your coverage continued under group health plans, including the medical expense reimbursement portion of this plan. Upon your return from a military leave of absence, you may have a right to reinstate your coverage.

Please contact Risk Management as soon as you know you will be taking a family or medical leave, military leave, or going on layoff or suspension.

DEFERRED COMPENSATION

As a City employee, you can participate in a 457 Deferred Compensation plan. Under a deferred compensation plan, you can make pre-tax contributions bi-weekly though payroll deduction into a variety of investment options to save for retirement. By setting aside a portion of your income to accumulate on a tax-deferred basis, you pay less tax dollars now, and your savings and investment earnings accumulate tax-deferred until you start drawing from the plan at retirement. The City of Saint Paul offers employees a choice of two deferred compensation plans:

ING administered by ING Financial Advisers LLC

Minnesota State Deferred Compensation Plan (MNDCP),
Administered by Minnesota State Retirement System

Both plans offer a wide range of investment options, each designed to pursue a different investment objective. Contact plan representatives for:

- Information describing the plan and its options.
- Prospectuses describing individual investments and their history.
- Help with enrollment and enrollment or change forms.
- Catch-up rules.
- Emergency withdrawal information.
- Payout information.

How Deferred Compensation Works

- You decide how much of your salary you want to defer and complete the appropriate participation/enrollment materials. You can contribute as little as $10 per pay period or as much as the maximum of 100% of gross pay or $15,000 annually – whichever is less. If you're age 50 or over, you can set aside an even higher amount. In the last quarter of 2008 the IRS will announce the cost-of-living increase adjustment for 2009 maximum deferrals.
- The City will deduct those contributions from your paycheck before State or Federal income taxes are taken out, and forward them to the deferred compensation plan administrator on a regular basis.
- You choose how to invest your contributions from the investment options offered under the plan.

- Contributions and earnings accumulate tax-deferred. You are subject to State and Federal income taxes only when you receive benefit payments.
- The plan has no effect on Social Security or PERA. Your Social Security and PERA benefits are based on your total pay, including the amounts paid into the deferred compensation plan.
- You can change your deduction amount or stop and start your deductions whenever you choose.
- You can change your allocation and investment options within the plan whenever you choose.
- You can elect to move your assets from one deferred compensation plan to the other during the month of October (October 1 – 31); the assets remain tax-deferred.
- You can't actively contribute to both plans (ING and MNDCP) at the same time, but you can have assets invested in both plans at once.
- Employer matching contributions may be deposited into the plan to which you are contributing.
- Withdrawals from a deferred compensation plan are generally only allowed when you retire, separate from City employment, or die.

Eligibility

The deferred compensation plans are available to all City employees, even those not eligible for insurance.

Reasons to Enroll

By deferring compensation, you have the opportunity to:

- Lower your current income taxes because you postpone paying taxes on contributions and investment earnings until you withdraw them (when you may be in a lower tax bracket).
- Enjoy the advantage of tax-deferred compounding.
- Accumulate more for retirement than you would with an after-tax retirement savings plan.

The Power of Saving

To show how contributing toward retirement on a before-tax basis affects your paycheck, let's assume you earn $30,000 in taxable income annually and you want to defer $100 from each paycheck to a deferred compensation plan, and you're in a 30% combined State and Federal tax bracket. You are paid every other week – 26 times a year.

	PAYCHECK BEFORE JOINING PLAN	PAYCHECK AFTER JOINING PLAN
Income After Adjustments	$ 1,154	$ 1,154
Def Comp Contribution	$ – 0	$ – 100
Net Taxable Income	$ 1,154	$ 1,054
Income Tax (30%)	$ – 346	$ – 316
Take-home Pay	$ **808**	$ **738**

With deferred compensation, your current State and Federal income tax is reduced, so it only costs you $70 out-of-pocket to invest $100. Now, see how the $100 bi-weekly contributions could accumulate over a long period of time:

	AFTER-TAX SAVINGS PLAN	DEFERRED COMPENSATION PLAN
Biweekly Contribution	$ 100	$ 100
Less Income Tax (30%)	$ – 30	$ – 0
Net Biweekly Contribution	$ 70	$ 100
Net Yearly Contribution	$ 1,820	$ 2,600
After 5 Years	$ 10,271	$ 15,449
After 15 Years	$ 39,889	$ 67,508
After 25 Years	$ 87,677	$ 169,917
After 30 Years	$ 121,640	$ 253,767

The above information assumes an annual effective interest rate of 7% and a 30% combined Federal and State tax bracket. These amounts are for illustration purposes only, and do not represent the performance of any investment options. Savings totals do not reflect fees or expenses associated with the deferred compensation plan.

Plan Comparison

If you are interested in the deferred compensation plans, you can receive a complete plan-to-plan comparison at any open enrollment session from either ING or MNDCP representatives. The plan-to-plan comparison includes information on rate of returns, individual operating expenses, and total fund expenses.

The comparison information on the next page provides an overall comparison of the plan features provided by ING and the MNDCP. Specific questions should be directed to the plan representatives.

	ING	MNDCP
Local Plan Administrator	ING 100 Washington Ave, Suite 730 Minneapolis, MN 55401	Minnesota State Retirement System 60 Empire Drive, Suite 300 St Paul, MN 55103
Local Representative Phone Numbers	Mark Isenberg 612/492-0209 or Michael Stein 612/492-0213 8:00 a.m. to 4:30 p.m.	(651) 284-7723 8:00 a.m. to 4:30 p.m.
National Representative Phone Numbers	(800) 262-3862 Mon-Fri 7:00 a.m. to 9:00 p.m. Sat 7:00 a.m. to 3:00 p.m.	(877) 457-6466 (option 2) Mon-Fri 8:00 a.m. to 4:30 p.m.
Automated Telephone Voice Response System	(800) 262-3862 24 hours a day - 7 days a week	(877) 457-6466 (option 1) 24 hrs a day - 7 days a week
E-mail Questions	*www.ingretirementplans.com/contact_us/index.shtml*	*www.mndcplan.com*
Website	*www.ingretirementplans.com*	*www.mndcplan.com*
Investment Options	43 Investment options 42 Variable funds 1 Fixed interest account	15 Investment options 13 Variable funds 6 Retail mutual funds 2 Fixed interest accounts
Self-Directed Brokerage Account	ING Ultimate Account 10,000 Mutual funds $2,500 Initial deposit $5,000 Balance required in core account	This account is provided through Ameritrade, and has 14,000 mutual funds available. Initial minimum transfer is $1,000 and $1,000 thereafter.
Quarterly Account Statements	Yes; mailed to home.	Yes; mailed to home.
Financial Planning Services	Available at an extra charge.	Not available at this time.
Enrollment	Personal one-on-one service with a local representative. Can be done any time during the year at the work site on employee time, or at a location and time convenient for the employee, including at home in the evening.	Personal one-on-one service with a local representative. Can be done any time during the year at the work site on employee time.
Annual Account Fees	None	None
Daily Asset-Based Charges	Daily asset charge applies to the entire variable fund balance as follows: 0.45% on ING funds; 0.45% on non-ING funds.	Daily asset charges are capped on balance in excess of $100,000. 0.10% annual maximum of $100.
Fund Operating Expenses	0.34% to 1.15%	0.01% to 1.27%
Expenses: Load, Risk & Mortality, Annuity Purchase, Transaction Fees, Surrender Charges	None.	None.
Self-Directed Brokerage	$50 Annually	$60 Annually
Fee for Minimum Distribution	None.	None.
Compensation for Reps	Commission	Salary

Enrollment

You can enroll or cancel participation in a deferred compensation plan any time during the year. You can change your deduction amount or stop and start your deductions whenever you choose. However, you can only elect to move assets from one plan to another (i.e., ING to MNDCP or MNDCP to ING) from October 1 – 31. To enroll or make changes, contact a plan representative for the appropriate forms to complete.

The deferred compensation program is meant for long-term savings only. It should not be considered for short-term needs. Do not participate if you cannot afford to leave invested money untouched until retirement, or if you do not have other savings set aside for emergencies.

Moving Assets From One Plan to Another

You may enroll in either the ING or Minnesota Deferred Compensation Plan any time during the year, but you can only elect to move assets from one plan to another (i.e., ING to MNDCP or MNDCP to ING) from October 1 – 31). The assets remain tax-deferred. You must complete two forms; one to transfer assets out of the plan, and the other to transfer assets into the other plan. Some of the fixed funds may have restrictions on the amount you may transfer. Forms are available from ING and MNDCP representatives.

Website

	ING	MNDCP
Web Address	*www.ingretirementplans.com*	*www.mndcplan.com*
Capabilities	♦ Current balance ♦ Daily fund quotes and market updates ♦ Fund performance ♦ Change investment elections (fund and allocation changes) ♦ Plan information ♦ Order literature and prospectuses ♦ Asset allocation worksheet ♦ Retirement planning calculator ♦ Investment growth calculator ♦ Links to Social Security, Elderweb, and Caregivers.com	♦ Current balance and contribution history ♦ Current fund allocation ♦ Daily fund quotes and market updates ♦ Fund performance ♦ Change investment elections (fund and allocation changes) ♦ Transfer rebalancer and dollar-cost averaging ♦ Download forms and plan materials ♦ Retirement income software (incorporates MNDCP, PERA, and Social Security) ♦ Withdrawal Quote System (provides retirement estimates and payout options) ♦ Links to PERA, Social Security, retail mutual funds, and the IRS

Payment Choices

You can start receiving payment from your deferred compensation plan as soon as 30 days from separation of employment. But, you don't have to withdraw funds until age 70 ½. All payments will be taxed as ordinary income in the year received, so you should discuss your income tax liability with an accountant or attorney before choosing an option. You can receive your benefits in any one of the following ways:

- Distribution over your lifetime.
- Distribution over your lifetime and the lifetime of your designated beneficiary.
- Distribution over a set period of time not extending beyond your life expectancy.
- Distribution over a set time period not extending beyond the joint and last survivor life expectancy of both you and your designated beneficiary.
- Lump sum or partial lump sum distribution in combination with one of the other options.
- An estate conservation option that allows you to receive only the minimum amount required by law at either age 70 ½ or retirement, whichever comes later.
- A systematic withdrawal option that provides periodic income for either a specific dollar amount or a specified time period at retirement or separation from service.

Death Benefit

Upon your death, your plan beneficiary will receive benefits according to options/time frames outlined in the plan. If you die before benefits commence and your plan beneficiary is also your spouse, he or she is not required to begin receiving payments any earlier than when you would have reached age 70 ½.

Emergency Withdrawal

Generally, withdrawals from a deferred compensation plan are not allowed unless you retire, separate from service, or die. However, a withdrawal can be made to meet an "unforeseeable emergency" as defined by the Internal Revenue Code. An unforeseeable emergency means a severe financial hardship to the participant resulting from:

- A serious illness or accident of the participant or beneficiary, the participant's or beneficiary's spouse or dependent.
- Major loss of the participant's or beneficiary's property due to casualty.
- Similar extraordinary and unforeseeable circumstances arising as a result of events beyond the control of the participant or the beneficiary. This does not include the purchase of a home or car, or payment of college expenses.

Emergency withdrawals are processed by each deferred compensation provider. Contact your plan administrator for an application.

OPEN ENROLLMENT INFORMATION

October 1 through October 17, 2008

Elections will only be accepted during this period and will become effective on January 1, 2009

Please attend one the sessions below for information from the following providers:

- **Employee Benefits** Online Enrollment Questions
- **HealthPartners** Medical Plans, Optional Dental Plan
- **Maxim** Flu Shots
- **MNDCP and ING** Deferred Compensation
- **Hays Companies** Optional Coverages
- **Outsource One** Flexible Spending Accounts

Wednesday, October 1
10:00 a.m. to 2:00 p.m.
City Hall Conference Center
Room 40 A & B

Monday, October 6
8:00 a.m. to 11:00 a.m.
Fire Department Headquarters
Apparatus Floor
100 E. 11th Street

Tuesday, October 7
8:00 a.m. to 11:00 a.m.
Fire Department Headquarters
Apparatus Floor
100 E. 11th Street

Tuesday, October 7
12:30 p.m. to 4:00 p.m.
Dale Street Garage
2nd Floor Training Room
891 Dale Street North

Dale Street Employees:
12:30 – 2:00 Sewer Maintenance/Municipal Equipment
2:00 – 3:00 Street Maintenance
3:00 – 4:00 Traffic Operations

Thursday, October 9
7:30 a.m. to 11:00 a.m.
Water Treatment Plant
McCarrons Room
1900 North Rice Street

Water Employees:
7:30 – 9:30 Field Employees
9:30 – 11:00 Office Employees

Water and Police K9 Unit Employees only

Friday, October 10
7:00 a.m. to 10:00 a.m.
Como Shop
Carpenter's Garage
1100 Hamline Avenue North

Friday, October 10
11:30 a.m. to 2:30 p.m.
Police Department (Griffin Bldg)
1st Floor Community Room
367 Grove Street

Monday, October 13
9:00 a.m. to 1:00 p.m.
City Hall Conference Center
Room 40 A & B

IMPORTANT PHONE NUMBERS

City and County Credit Union (651) 225-2754	Your City and County Credit Union offers many services: savings, checking, ATM/debit cards, online services, VISA credit cards, car loans, personal loans, mortgages, and more.
Hays Companies 612-347-8410	Hays Companies can answer general questions about the various optional insurance plans.
HealthPartners BabyLine℠ Service (952) 333-BABY (2229) (800) 845-9297	If you're pregnant or up to six weeks post-partum, you can call the HealthPartners BabyLine service to speak with specially trained nurses about medications, breast-feeding, unfamiliar aches and pains, mood swings, or other pregnancy-related concerns.
HealthPartners CareCheck® Program (952) 883-5800 (800) 942-4872	You can call the CareCheck program 24 hours a day. You must notify CareCheck before hospitalizations or same day surgeries when using an out-of-network provider.
HealthPartners CareLineK Service (612) 339-3663 (800) 551-0859 TTY (952) 883-5474 TTY (800) 983-5474	The HealthPartners CareLine service offers skilled medical professionals who are specially trained to assess medical conditions of all kinds. When you call after regular clinic hours, a CareLine nurse might suggest home care, a visit to your clinic, a trip to an urgent care clinic or a visit to the emergency room, depending on your condition.
HealthPartners EAP (866) 326-7194 TTY (800) 827-3707	HealthPartners EAP provides confidential counseling and referral services to you and your family at no cost, 24 hours a day, 7 days a week. HealthPartners EAP can help resolve relationship, mental health, legal, domestic issues, substance abuse, gambling, financial, or work concerns.
HealthPartners EAP Management Line (866) 326-7194 TTY (800) 827-3707	HealthPartners EAP also offers the Management Line, a unique resource for managers and supervisors. Management Line consultants provide information and support to help managers deal with personnel concerns. The Management Line complements the City's internal resolution processes with an objective third-party perspective without replacing or infringing upon personnel policies or services.
HealthPartners Member Services (952) 883-5000 (800) 883-2177 TTY (952) 883-5127	HealthPartners can answer any questions you have about network providers, specific benefits provided through the City's group medical plan, or assist you with changing your primary medical or dental clinic choices.
HealthPartners Behavioral Health Personalized Assistance Line (PAL) (952) 883-5811 (888) 638-8787	HealthPartners PAL staff can match you with the network provider that best meets your behavioral needs. They can identify providers based on specialty, and on specific diagnostic, language, and cultural competence.
ING (612) 492-0209 or 0213 (800) 525-4225	ING is a City deferred compensation plan administrator. They can help you understand and enroll in the ING deferred compensation plan. This can be done anytime during the year; it is not limited to open enrollment.
MNDCP (877) 457-6466	Minnesota Deferred Compensation Plan is a City deferred compensation plan administrator. They can help you understand and enroll in the State of Minnesota Deferred Compensation Program. This can be done anytime during the year; it is not limited to open enrollment.
Outsource*One* Flexible Spending Accounts (612) 436-2778 (877) 491-5979 Fax: (612) 335-9217 (877) 491-6016	Outsource*One* can assist you in determining allowable expenses for reimbursement through the flexible spending accounts, and assist you with completing the reimbursement request (claim) form.
Risk Management (651) 266-6500	Employee Benefits staff are always available to answer questions or direct you to the appropriate resource. Most questions regarding benefit eligibility, negotiated employer contribution amounts, payroll deductions for insurance coverages, and specific information on rules for changing benefit elections should be directed to Risk Management.

Use this Benefit Booklet for reference throughout the year!

EMPLOYEE ACKNOWLEDGMENT

1. I understand that employee pre-tax dollars spent are also excluded from income eligible for FICA (Social Security) deduction.

2. I understand that employee pre-tax dollars spent will reduce income eligible for deferred compensation contribution.

3. I understand that the IRS value of employee life insurance in excess of $50,000 is taxable income and is subject to FICA deduction.

4. I understand that if I apply for coverages requiring evidence of insurability, and the coverage is subsequently denied, the selection will be stricken from Benefit*Ready* and I will not be allowed to re-select until the next open enrollment.

5. I understand that if I schedule a voluntary leave during the monthly qualifying pay period which results in a pay check insufficient for payroll deduction, I will be required to make a direct payment for my portion of the premium and the payment will not qualify for pre-tax deduction.

6. I understand that the following changes in status will require the completion of a change form:

a) A change in bargaining unit if the new bargaining unit offers different benefit options; and

b) A change from full time to part time status, and vice versa, if my bargaining unit agreement requires or allows an election change under these circumstances.

7. I understand that participation in the Cafeteria plan cannot become effective until the appropriate enrollment has been completed.

8. I understand that no mid-year changes may be made to my elections for medical and dental insurance unless they are allowed under the Cafeteria plan, federal law, and provider contract.

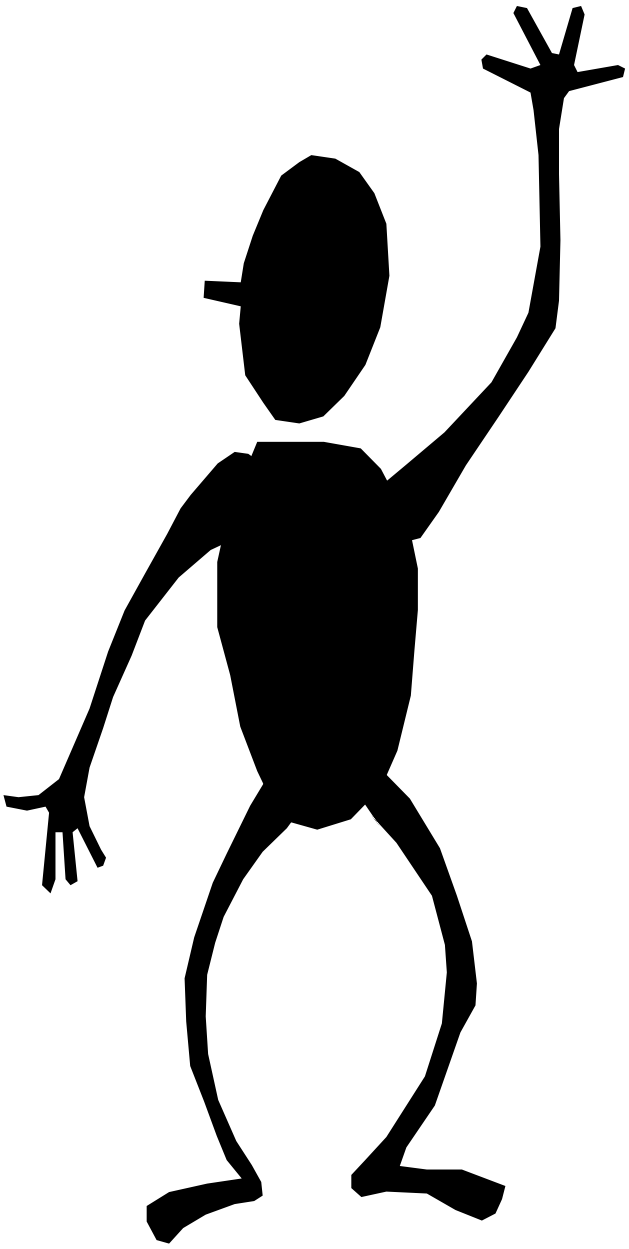
9. I understand that post-tax life insurance, short term disability, long term disability, and accidental death and dismemberment coverages are subject to enrollment and cancellation as a new employee and at open enrollment only, and that mid-year changes are not allowed.

10. I understand that if I currently carry single coverage and I do not enroll in Benefit*Ready* by October 17, 2008, I will have elected, by default, to enroll in the Single HealthPartners Primary Clinic Choice with Deductible Plan, and continue my other current insurance coverages.

11. I understand that if I currently carry family coverage, and I do not enroll in Benefit*Ready* by October 17, 2008, I will have elected, by default, to enroll in the Family Open Access with Deductible plan, and continue my other current insurance coverages.

12. I understand that if I currently carry no medical and I do not enroll in Benefit*Ready* by October 17, 2008, I will elect to waive medical coverage, and continue my other insurance coverages.

13. I understand that if I fail to re-enroll in a flexible spending account for 2009 by October 17, 2008, my participation will be terminated at the end of the 2008 plan year.



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City & County is a great option for your financial needs. Your best interests are also our best interests. All profit is returned to our members in the form of better rates and services. Every member here is equal and important. Join today!

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1661 Cope Avenue E. - Maplewood
1420 Yankee Doodle Rd. - Eagan
8500 Hudson Blvd. N. - Lake Elmo

All Offices:
651-225-2700
www.cccu.com

City employees can join, as well as anyone and any business in Ramsey, Washington or Northern Dakota County.

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